

1988

A medical examination assessing power and social influence in the patient-physician relationship.

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A MEDICAL EXAMINATION:
ASSESSING POWER AND SOCIAL INFLUENCE
IN THE PATIENT-PHYSICIAN RELATIONSHIP

by

David Joseph Dekindt

A Thesis
submitted to the
Faculty of Graduate Studies and Research
through the Department of
Sociology and Anthropology in Partial Fulfillment
of the requirements for the Degree
of Master of Arts at
the University of Windsor

Windsor, Ontario, Canada

1987

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ISBN 0-315-43741-3

11-21-96

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ABSTRACT

A MEDICAL EXAMINATION: ASSESSING POWER AND SOCIAL INFLUENCE IN THE PATIENT-PHYSICIAN RELATIONSHIP

By
David Joseph DeKindt

This thesis deals with the basic question of power in the medical profession. Specifically, it deals with patients' perceptions of the effectiveness of the various bases of social power and influence as applied in the patient-physician relationship.

Social researchers and health care specialists have identified at least two contrasting views of the locus of power in doctor-patient relationships. One has been labeled as the traditional, or "patient as inferior" model. The other view can be called the antielitist, or the new "patient as equal" model.

In the traditional model, power is asymmetrically distributed, resting entirely in the hands of the physician. The new "patient as equal" model looks at the distribution of power in the doctor-patient relationship in a different light, where power is shared as a meeting between equals.

This study explored and analyzed the subjective experiences of seventeen patients with regard to power and social influence in the patient-physician relationship. From the array of recorded interview responses, doctor and

patient typologies were developed as a means of organizing and explaining the characteristics that patients perceive about themselves and their physicians.

The process of interaction between patient and physician was divided and analyzed in three stages: (1) the stage "prior to interaction," (2) the stage concerning "face-to-face interaction," and (3) the stage "after the interaction." An analysis of patient responses within each of these stages revealed that patients and doctors employ the use of particular strategies and negotiations in an attempt to control the interaction process. It was concluded that many patients perceive doctors as having more techniques available to them insofar as gaining and maintaining power and social influence within the doctor-patient relationship.

Patients efforts to succeed in the interaction process - in terms of reporting "good" experiences with their physicians - was highly dependent on the nature of the patient's illness as well as the individual nature of the physician and the patient themselves. The analysis of the three stages of interaction indicated that the traditional model and the new patient as equal model can work for certain people under certain circumstances.

ACKNOWLEDGMENTS

The initial idea for this thesis was first inspired by a series of discussions with faculty, fellow graduate students, and friends at the University of Windsor. I am indebted to all those who shared my early enthusiasm for the research and for their support and encouragement throughout the completion of this project.

I am most grateful to my committee members, Barry Adam, Jack Ferguson, and Janet Rosenbaum for their invaluable assistance, careful criticisms and insightful additions to my ideas.

To my family and friends I wish to offer my heartfelt thanks for their support; especially to Mom, who only occasionally complained about the "organized mess" of books, notes, and interviews that occupied the dining room table for most of the summer.

I wish to offer a special thank-you to Marion Keith, whose friendship was indispensable to me in this venture. For long hours of detailed discussion, insights, challenges, gentle corrections and unstinting encouragement, I owe you more than I can say.

Finally, this thesis draws much of its illustration from a study of patients' perceptions of their doctors, and therefore owes an enormous debt to those individuals who freely gave their time to be interviewed.

David DeKindt

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INTRODUCTION

Hold the physician in honor for he is essential to you and God it was who established his profession. From God the doctor has his wisdom. Thus, God's creative work continues without cease. He who is a sinner towards his Maker will be defiant towards his doctor.

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In contemporary American culture, it is appropriate for doctor and patient to meet as equals, with the former rendering expert advice and the latter bearing ultimate responsibility for deciding whether or not to follow that advice. Moreover, we believe that enlightened consumer opinion...now make[s] it feasible to routinely structure clinical relationships in this way (Katon & Kleinman, 1981).

The above statements are taken from Haug and Lavin's Consumerism in Medicine (1983:9). The first of these statements is posted on the wall of a physician's office in a small town in Ohio, with a note that the author is unknown. The second is from a book by two physicians located in two medical schools (Katon & Kleinman, 1981). They represent contrasting views of the locus of power in doctor-patient relationships. In the first the power is asymmetrically distributed, resting entirely in the hands of the physicians. The second, however, suggests an alternative where the power is at least partially shared as a meeting between equals.

This thesis deals with the basic question of power within the medical profession. Specifically, it deals with the effectiveness of the various bases of social power and influence as applied in the physician-patient relationship. Within the medical profession, expertise is

the most frequently used source of power that allows authority figures such as physicians to exert social influence over their patients. David Mechañic (1968:424) points out that power stemming from expertise is greatest when it is difficult to replace the expert. This is clearly the case in the medical profession. As Ivan Illich (1976:50) notes, physicians wield a great deal of influence and control over human society and own a "medical monopoly" in the health care field. In other words, if one is experiencing some health related problem that requires attention, he or she, often out of lack of any alternative, is reliant upon the expertise of the medical profession. This "reliance" can become very problematic in terms of motivating doctors to treat patients as equals, as we shall see.

The central focus of this study was to explore and analyze the subjective experiences of patients with regard to power and social influence in the patient-physician relationship. By interviewing patients we can come to understand the symbols and meanings and roles reflected in their interaction with physicians. We can also reach a better understanding of why patients and doctors "act" the way they do; what influencing strategies they employ to exert control within their encounters; and how problems resulting from unmet expectations are being handled by patients and physicians.

The findings and conclusions presented in this study are not intended to be generalizable to an entire population (i.e. in terms of sex, race, age, or social background). They are, however, intended to be a subjective account of what some patients are saying about power and social influence in the patient-physician relationship. Hopefully, this study can serve as a basis for further interdisciplinary research into the interactional experiences of doctors and patients.

CHAPTER ONE

REVIEW OF THE LITERATURE THE PHYSICIAN-PATIENT RELATIONSHIP: TWO MODELS

As alluded to earlier, one can see that at least two viewpoints exist that are in conflict as to what the "ideal" doctor-patient relationship should be. These viewpoints have become known as the traditional and the antielitist perspectives which are in conflict in many other areas besides health care.

THE TRADITIONAL VIEW: PATIENT AS INFERIOR

Elliott Krause (1977) has suggested that, traditionally, the trust of the patient in the complete competence of the doctor and the dependent desire to be "taken care of" by the doctor, have been considered essential aspects of the relationship. Since almost all physical illnesses have a psychological component and a psychological effect, the psychiatric model has become quite popular in liberal academic medicine as the model for the nature and quality of the interpersonal relationship between physician and patient, in all fields of medical practice. In effect, the general practitioner and the specialist are urged to educate themselves in psychiatric areas, or get mental health training, so that they may minister to the emotional as well as the medical needs of the patient (Krause, 1977:98).

Although this updating and broadening of the clinical role, and the professionalizing of the human relations aspect of it, has some common sense to it, there are real dangers of abuse of power (especially in terms of coercive/reward power, and expert/ legitimate power). Krause² notes that in the traditional or "psychiatric" model of medical authority with respect to the passive dependent patient, objections by the patient become filtered through the "clinical" or "psychiatric" screen which lies before the eyes of the doctor. He says:

Objections by the patient about the unequal power positions in the relationship, problems associated with being ill, or problems paying the bill, come to be interpreted by the physician as manifestations of illness. That is, any aspects of the attitudes, emotions, and behaviors of the patient can become fair game under the psychiatric model (1977:98).

Krause goes on to point out one essential element of the doctor-patient relationship that has not been changed as physicians come to embrace the psychiatric model: the unquestioned total authority of the physician to pronounce on all aspects of human existence to the patient. This parallels Irving Zola's claim that historically medicine is an occupation whose very practice is enmeshed with society, and has a built-in social influence from the very start (1972:488).

Krause makes an important claim concerning social class differences relating to the view of patient as inferior. He contends that most poor people, as well as

most working-class and middle-class people, will at present agree with this authoritarian model and take it as normal and expected behavior on the part of the physicians towards them. "They may either want the physician to act this way, or, more probably they could not conceive of a physician acting any other way" (1977:98).

Krause's concerns are backed up by feminist analysis of physician-patient interaction focusing on how typical role relationships between women and physicians are related to women's general social status. Antoinette Groesser (1972:13) notes that the most common interaction style mirrors the parent-infant relationship. Termed the activity-passivity model, it is the traditional clinical relationship. Groesser (1972:14) also speaks of the mutual participation model, an adult form of interaction that is exceedingly rare in the current physician-patient relationship. In this mode, patients with power and money are more likely to be treated as adults, whereas those without it are more likely to be treated as children. Women and members of lower economic groups are typically treated as inferior. Research suggests that gulfs in social class can affect the way doctors and patients interact. Studies conducted mostly in the 1950s suggest that the greater the social distance between participants, the worse the therapeutic relationship. Mutual respect, trust and cooperation seem to dwindle as the social

distance widens. The doctor and patient become so preoccupied with their positions in the social hierarchy that they give less attention to the goal: healing (Corea, 1977:75).

Because most people seek equality and individual self determination in every aspect of life, interaction with physicians who view the patient as inferior can be galling. For example, Sheryl Burt Ruzek (1978:34) reports that women who attempted to interact in gynecological examinations in the mutual participation, or adult mode, were met with everything from astonishment to open hostility.

Women's basic complaints all reflect serious disagreement over appropriate style of patient-physician interaction, access to information, and right to decision making in health matters. These were and are especially burning issues, because many standard medical practices and procedures were found to be ineffective or hazardous in the late 1960s and early 1970s. Unless women can interact with physicians in a style allowing full exploration of risks and hazards associated with routine treatment modalities (including contraception, abortion, treatment for routine gynecological disorders, and childbirth), they are unable to make informed decisions (Ruzek, 1978:34). In Barbara Seaman's (1972) opinion, patient passivity, whether enforced or willing,

- contributes significantly to many inappropriate and hazardous medical practices.

Overall it is the attitude of the physician that many women are complaining about. As gynecologist Sadja Goldsmith notes:

Women want to be treated as equals. They don't want to be talked down to. They want doctors to answer questions and explain what's going on. Women feel they can't talk to their doctors. They want more honest discussion. They want to be brought in as decision makers (Stephen, 1973:20).

THE NEW MODEL: PATIENT AS EQUAL

Hence, there is another way of looking at the distribution of power in the physician-patient relationship where power is shared as a meeting between equals. Characteristically, in societies with a equality ideal, such as North America, the relationship of service should literally be meant as such: The server (doctor) is to "serve" the served (patient), on terms defined as much by the served as the server. The People's Republic of China provides an excellent example of how the relationship of physicians to patients can operate when a society has a radical equality goal. Joshua Horn (1969:53) observes:

The relationship between patients and doctors in China is based on equality and mutual respect... There is no room for a superior or patronizing attitude on the part of the doctor and neither is there any room for bluff heartiness, false formality, or any other of the devices which often masquerade as a "bedside" manner."

The patient's right includes the right to know what is wrong, why, and what is going to be done about it. Horn (1969:53) notes:

The doctor's job is unreservedly to serve the interests of his patients. Chinese patients, like patients all over the world, like to have things explained to them. They want to know what they are suffering from, how long it will take to get better, and what treatment they are having. It is part of the doctor's duty not only to explain this fully when asked, but to volunteer such information even when not asked.

Thus, it would appear that under Maoist ideology, all experts are to "serve the people" and really do so, not as a figure of speech. This is not to say that the health-care field in China itself is not without its share of "backsliders" or elitists who do not enjoy this relationship with their patients any more than a North American physician might. But the model itself is a different one. As Elliott Krause (1977:99) states, "....it grants expertise to the physician but it does not allow the expertise or the psychological dependence of the ill on the practitioner to become the justification for a dominant power relationship". In other words, the new "equality" model does not allow one party to feel for whatever reason, that he or she may legitimately manipulate the other for "medical reasons," refuse to inform the other as to what the reason for treatment, or show any sign of simple disrespect.

Feminist health care embraces Krause's concept of

patient as equal. Like Krause, feminists see people's health problems not as individual pathologies but as shared outcomes of the kind of society we live in. For women, this means acknowledging that sexist ideas and behavior can make you sick, and therefore that in order to be healthy, these ideas and behaviors must be changed (Webb, 1986:186). Sharing knowledge and power between physicians and patients, breaking down the barriers of unequal relationships, and supporting people as they make decisions and make their own health choices are ways in which feminists work towards change.

SOURCES OF POWER AND INFLUENCE IN THE PHYSICIAN-PATIENT RELATIONSHIP

An individual's power is his or her ability to shape another's behavior, that is, his or her potential influence (Rodin, 1982:55). There are several sources of power that allow authorities such as physicians to exert social influence over their patients, but fewer sources are available to the patients. French and Raven (1959) have identified six sources of power: (1) coercive power, (2) reward power, (3) legitimate power, (4) expert power, (5) informational power, and (6) referent power. It should be noted that these power bases overlap somewhat in regards to their use in physician-patient interaction.

REWARD & COERCIVE POWER

The interpersonal context of the physician-patient relationship provides considerable opportunity for the physician to use coercive and reward power. Coercive power stems from the ability of the influencing agent to mediate punishment. Reward power stems from his or her ability to mediate rewards. Coercive and reward power usually require surveillance to be effective (Rodin, 1982:56). Praise, warmth, time, and availability are but a few of the examples of reward power that physicians can convey or withhold, contingent on the patient's performance. Some physicians give their favorite patients such rewards as free drug samples or even reduced rates, so economic incentives also contribute to the basis of their reward power. Patients seeking these rewards may consciously engage in "good-patient behavior" often at great personal cost to their health and well-being (Taylor, 1979:176).

Coercion enters the relationship when a physician threatens to deny further service or refuses to provide a desired prescription. Such threats can compel patients to act against their own wishes. Sometimes threats may be very meaningful (for example, threatening not to recommend insurance or medicare payments unless the patient complies). However, according to B.H. Raven, more often than not, it is the approval of the physician and disapproval for noncompliance that carry reward power.

"For approval and disapproval to be effective, the patient must like and value the physician" (Rodin, 1982:15). Thus, in this sense, liking and valuing one's physician, but not seeing oneself as an equal, can magnify the power differential between doctor and patient.

INFORMATIONAL POWER

In recent years, health care scientists have suggested that informational power is used frequently by physicians, but not always effectively. Often problems arise from the inability to appreciate what the patient knows or does not know -- a use of technical/medical language may sometimes impress the patient with the physician's expertise but yet fail to give the patient a clear rationale for prescribed behavior. Social researchers point out that the physician must be able to explain clearly and persuasively exactly how the prescribed behavior will be helpful. But, physicians must also be willing to share information with their patients. Haug and Lavin (1983:12) note that it was Parsons (1951) who implicated unshared knowledge in the right of the physician to exercise control over patients. Parsons' conception of the sick role is embedded in the notion that illness is a form of deviance that upsets the balance of the social system, with doctors the instrument of social control that corrects the deviance. The obligation for the

patient to comply is rooted in the "competence gap," the difference between physician and patient in knowledge held, a gap that is unbridgeable (Parsons, 1975:260).

This model of the asymmetrical physician-patient relationship is congruent with Parsons' functionalist perspective, in which society survives through shared values and interrelated functions, with various accepted instruments of social control maintaining the whole system in equilibrium. However, in theoretical terms, the sick role model has been criticized by those who espouse a conflict theory of society. They argue that both doctors and patients ~~possess~~ possess some power and jockey for position in achieving wanted results. The major tactic used by physicians to retain their dominance is informational control by limiting information or couching it in strange technical language (Haug & Lavin, 1983:13). Patients try to contain that dominance by information seeking in the "micropolitics" of the medical encounter (Waitzkin and Stoeckle, 1976:265). In many cases, the patient can take his or her business elsewhere, spread the word about dissatisfaction with care, or even sue the doctor for malpractice.

To be sure, patients are also able to exert informational influence in the patient-practitioner dyad. Only they know the full range of their symptoms, where and how much it hurts, whether they really have taken all of

their medication , and the like. How they disclose this information and to what extent, has a major impact on the effectiveness of the patient-physician relationship.

It is evident that from a conflict perspective, the monopolization of knowledge that is used to control patients is the modern equivalent of the Marxist view of the monopolization of the means of production through which the capitalists and entrepreneurs are said to control the working class. Haug and Lavin (1983:15) note:

Producer-consumer and producer-owner relationships are both governed by the appropriation of tools, chiefly cognitive in the case of the professionals and chiefly mechanical in the case of the industrialist. The "revolt of the client" [sic. patient] (Haug & Sussman, 1969), in the form of consumerism, is then the analogue of the revolt of the worker against the owner. Consumers in the medical arena are able to challenge professional power when they acquire sufficient knowledge to encourage them to make choices between health care options.

Such a revolt would create a situation where the patient alone commands power in the relationship. A small "revolt" has taken place recently in light of legal challenges by law and health activist groups, which are demanding that hospitals let patients see their own records. "The right to know" is the catch phrase of these groups. But such action points up the need to change the whole social context of the physician-patient dyad rather than to tinker with one aspect of the relationship. What the above analysis fails to deal with is the fact that one is still left with an asymmetrical relationship. (Power

and social influence would merely shift from physician to patient). An adversarial relationship would continue to exist between doctor and patient, each grasping for power. Health care is too crucial an arena of human relations to withstand power struggles between participants. This is why social researchers speak of the importance of "equality" as a new model for defining the physician-patient relationship.

Feminist health care advocates state that the true sharing of knowledge and the demystification of technical jargon are only possible in a equal relationship in which neither partner has more rights or privileges than the other (Webb, 1986:183). This kind of sharing and equality allow open discussion and mutual questioning and challenging of opinions. Through these processes patients develop confidence in their ability to understand and take charge of their own health.

EXPERT AND LEGITIMATE POWER

In recent years, social scientists have been questioning the effectiveness and functionality of expert power in the physician-patient relationship. It has become apparent that as medicine becomes increasingly specialized, the use of expertise has become overplayed by many physicians as basis of social power. In most health care organizations the most obvious basis of social power is

expert power. The physician can emphasize his or her expert power with impressive diplomas on the walls, with a properly displayed library, and by an air of knowledgeability and expertise -- "Trust me, I know what is best for you - so just do as I say." Some social researchers fear that physicians are relying too heavily on expert power as a strategy to influence patients into doing "what is best for them." They maintain that the effectiveness of expertise as a means of making patients comply to doctors orders may not be as complete and long lasting as physicians might hope. Furthermore, the use of expertise also leads to increased personal distance from the patient, affecting both the physician's concern for the patient as a person and the patient's perception of the depth of concern by the physician (Johnson, et. al, 1982:14).

One reason expert power is so frequently used by physicians to exert social influence over their patients is because it is enmeshed with legitimacy. Expertise is based on the professional's "genuine skill and superior knowledge," and on the legitimacy of the professional role, which carries with it the right to exert influence. This basis of power is dependent upon its ability to make the patient comply to the physicians recommendations-- "Look do as I say, after all I am the doctor." This type of power has been described by Weber as "legal-

rational" authority. Acceptance is grounded in the recognition of the physician role as an official position as established by law or quasi-legal rules. Physicians enjoy this type of authority by virtue of laws governing licensure that forbid the practice of medicine by the unauthorized. Having the sole right to practice endows physicians with the authority of the state (Haug & Lavin, 1983:10). Thus, physicians can wield a great deal of influence on the patient knowing full well that they have a legally recognized monopoly in the health care field.

Health care often begins when the patient has a problem that is brought to the expert. This is generally reformulated by the expert after examining the patient and giving and analyzing tests. Throughout this diagnosis period, the physician is "in charge" of the problem-solving process by virtue of expertise and legitimacy (Stone, 1979:39). This may be one reason why he or she tends to concentrate on the medical aspects of the problem, for which his or her legitimacy and expertise are most relevant. Indeed pure expert power implies that the patient is obliged to do what the physician asks without ever questioning the logic of his or her request ("After all, you're the doctor"). But physicians using expert power, by virtue of their medical training and role, may exclude from consideration other aspects of the patient's life situation such as work commitments or child care that

may be critical determinants of the patients ability to carry out subsequent recommendations (Innes, 1977:637).

G.C. Stone (1979:41) points out:

The expert often does not know and fails to inquire about the meaning to the patient of such consequences as pain, impairment of sexual function, and embarrassment about public [or even private] display of therapeutic devices.

A useful article by Dr. Mary Howell (1979:2) lists four areas in which the professionalism doctors absorb with their medical training is in conflict with feminist values and the "patient as equal" model.

- 1 Professionals learn to be arrogant and disrespectful towards people assumed to be less important than themselves (eg. patients, receptionists, nurses).
- 2 It is assumed that as professionals, they deserve their privileges (eg. high income, [sic. power]).
- 3 Professionals believe that the knowledge and skill they have acquired entitles them to exert control over other people's lives. This also implies keeping their knowledge secret and mysterious.
- 4 Professionalism defines what is important, valid and scientific (e.g. which therapies are acceptable and which "fringe"; which patients have real diseases and which are wasting the doctors valuable time).

Under some circumstances, the use of expert and legitimate power may actually diminish feelings of personal control if patients feel that the doctor's advice and directions limit their freedom. According to J.W. Brehm, under these conditions people feel "reactance", a psychological experience that motivates them to restore lost freedom and regain a sense of control (1966:43). This type of reaction may explain why patients sometimes act against what would appear to be their best interests by

quitting treatment against medical advice. These patients may be attempting to restore freedoms that they perceive to have been taken away from them by health care professionals who use expert power, especially when they are told to eliminate pleasurable activities, such as food, or drugs, that they feel are an important part of their lives. According to Rodin, lack of adherence may sometimes be an active coping strategy on the part of the patient to restore a lost sense of control (1982:63).

The effects of a physician's expert power on a patient's perception of control are crucial to understand because these perceptions have significant health relevant outcomes. On the basis of social-psychological research bearing on the differential effects of various sources of power, one may expect that when patients comply because of the expert power of the health-care professional, they will contribute their compliance to the external incentives provided by him or her and will less likely perceive themselves as having personal responsibility for, or control over, their own health-relevant actions (Rodin, 1982:62). Thus, one can hypothesize that this will prove disadvantageous to a patient's short or long-term health care.

Another reported result of patient dissatisfaction with their medical care as a result of their physicians' relying too heavily upon expertise, is that patients can

often inflict serious harm on themselves. Patients who discover they are ill need much empathy and understanding and also attention to their feelings, concerns, and fears. If their health-care professionals do not provide these important aspects of care and give patients both reassurance and information about what will be done for them, seriously ill patients can easily feel abandoned by their physicians. They are likely to reject the medical establishment and seek non-medical cures.

Beatrice Cobb (1954) examined the reasons given why some cancer patients reject the medical profession (with its low but nevertheless existing cure rate for the disease) and seek non-medical cures (for example, religious healers or herbal cures, although a few opportunists have recently employed the use of bogus lasers which they tell patients can cure anything from a hangnail to serious infections). From Cobb's (1954:69) many interviews, she learned that these patients had "little reassurance from their physicians and other health personnel and were not sure that all that could possibly be done would be done for them."

Proponents of the antielitist model suggest, in the ideal situation, the patient should be able to rely on the health-care professional for continued support and for respect, care and concern for them as a person. Patients should be made to feel they are active rather than passive

participants. In the ideal case, the physician carefully explains the medical procedure to the patient. All the attendant risks are described, the expected results considered, and a trust is built up between physician and patient. A joint decision is then made, and if the treatment does not go as expected, the patient is informed and takes part in additional decision making.

REFERENT POWER

Social researchers have been questioning whether or not the ideal case outlined above can actually be realized. Recently, Rodin and Janis have emphasized the use of referent power, a power base that they feel can be particularly effective and that is not generally utilized by modern-day physicians. Of all the sources of power, referent power is probably the least used by medical profession at the present time. Rodin and Janis (1979:61) define referent power as:

... the social power that is based on the target's identification or desire for identification with the influencing agent, upon a perception of communality or oneness. Persons have referent power for those who perceive them as likeable, benevolent, admirable, and accepting, and their motivational power derives from this source.

In other words, referent power is based upon the patient's identification with the physician and a feeling of true communication. Unlike expert power, referent power is very effective in the social-emotional aspect of the physician-

patient relationship. It is the use of this source of social influence that promotes the new model of "patient as equal" as defined by Elliott Krause.

When used effectively, referent power does not require surveillance and also has the advantage of providing greater feeling of security and trust on the part of the patient. It is a basis of power that was most likely frequently used by the early family physicians. The skills of transmitting and receiving nonverbal communications seem especially important for the implementation of referent power (DiMatteo, 1982:67).

Among the techniques that social-psychologists suggest physicians utilize to establish referent power is the use of self-disclosure, thus, encouraging self-disclosure from the patient in return (Rodin & Janis 1979:71). In this regard, the physician is to make salient the similarities between himself or herself and the patient, particularly with regard to beliefs, attitudes, and values. Another technique is to talk and act in a manner that conveys a benevolent attitude toward the patient, an unselfish willingness to provide help out of a genuine sense of caring about the patient's welfare. Still another technique, which may overlap somewhat with the second way, is to be seen as accepting which conveys to the patient that "he or she is held in high regard as a worthwhile person despite whatever weaknesses and

shortcomings might be apparent" (Rodin & Janis, 1979:71). In short, physicians should give positive feedback, accept feedback, and emphasize the patient's health as a mutually desirable goal. There is evidence that the physician-patient relationship can be facilitated just by having the physician introduce himself or herself on a first name basis (Johnson, et. al, 1982:16). After developing referent power, the physician can also apply similar techniques to bring about acceptance of appropriate health-related behaviors and to perpetuate the effect of referent power after the patient has left the doctor's office.

The emphasis on referent power and mutual relationship raises the general question, alluded to earlier, regarding whether "compliance" with medical regimen, with the implications of the term, is really always desirable to begin with. To some social scientists, heavy use of expert power to make patients comply to doctor's orders, suggests an authoritarian relationship, a one way influence process, which may be incompatible with the values of the patient. Failure to "comply" is thus assumed to be the fault of the patient, or of the physician, who is not utilizing his or her authority properly. Some health scientists prefer the term "adherence," but even this suggests an automatic acceptance. The factors that lead to referent power

contribute to a two-way communication and influence process -- perhaps sometimes it is appropriate for the patient to influence the practitioner. For example, some studies have suggested that it is important that female patients whose physicians recommend radical breast surgery speak up and raise the possibility of alternative measures (Johnson, et. al, 1982:17).

Such concerns were reflected in feminist movements of the 1960s and 1970s, alarmed at the high incidence of radical hysterectomy and mastectomy and convinced that doctors over-treated and maltreated women patients, mounted an open attack on the medical profession. Feminists urged women to learn about their own bodies, to become less passive as patients, and in some cases, to treat themselves rather than trust to male medical practice.

An interesting innovation involving referent power that may improve doctor-patient relationships concerns the use of patients as instructors. Established physicians and physicians-in-training usually do not receive any direct feedback from their patients as to how well they are conducting themselves. As is often the case with the frequent use of expert power, patients are expected to keep silent unless asked a direct question. However, certain patients, especially those with chronic illnesses, are in an excellent position to evaluate how well a doctor

is doing both technically and interpersonally, and they may be able to help him or her improve.

In a recent study, patients, after receiving some basic medical training were made available to medical students. These patients, usually people who were suffering from multiple sclerosis, emphysema, a heart murmur, or some other chronic condition, were encouraged to respond to and instruct the students. Some patients are also willing and able to tell medical students such things as: "their hands are too cold, they forgot to wash their hands, or certain mannerisms are anxiety provoking" (DiMatteo, 1982:33). In this way, medical students can quickly learn through experience, particular skills in the use of referent power that will enable them to effectively meet the medical and psychological needs of their patients.

At this point it must be noted that the emphasis on a new model of "patient as equal," and the use of referent power and patient involvement in decision-making, should not be interpreted as asking physicians to deny their own responsibility for giving direction to patients. The patient's expectations of the relationship must also play an important role. Often a patient approaches the physician with a clear expectation and desire that the physician will use expert and informational power in simply prescribing an appropriate procedure. This idea

will be discussed in detail in section two.

Expert, coercive, and reward power may also be more effective than referent power where feelings of control are stress inducing for the patient, especially when the individual believes that there are actions he or she ought to be taking but is not able to initiate (Averill, 1973:292). Expert power may be especially advantageous in those instances where the patient would suffer from making futile attempts to control health-relevant outcomes that are uncontrollable. However, some researchers maintain that the use of referent power can still play an important role under the above conditions. Webb (1986:185) notes:

We [feminist health workers] face the contradiction, too, of being "experts" and having a great deal of power over those who use our services. We may think we have clear ideas about what would be the best decision for our clients, and they may want us to decide for them. Should we do as they wish and take the decision, or should we try to help them to be self-determining? Whichever we decide, we are using our power over them and, as Carol Smith (1983) says "even big strong dykes want to be looked after sometimes!" What we try to do is to share our knowledge and skills with people so that they can take decisions for themselves. And if they then decide that they prefer a professional to take action on their behalf, they have made an informed choice.

Furthermore, it has been suggested that referent power is likely to promote internalization of physicians' recommendations and adherence under conditions where salient external inducements for decision-making are absent. Internalization is the propensity to perform a recommended behavior even when one is removed from time

and/or place from the source of influence (Johnson, et. al, 1982:62). One would expect that the circumstances that promote internalization also serve to increase patients' feelings of choice and control because they perceive themselves to be acting on the basis of internal, self-motivated norms and goals. Research in other contexts has shown that greater feelings of control and causality increase behavioral commitment and play an important role in facilitating "adherence." These are added reasons why the use of referent power may be important influence techniques for physicians to develop.

Evidence suggests that an emphasis on referent power in the physician-patient relationship can also have positive repercussions in preventive health-care (Rodin & Janis, 1979:75). People are more likely to take preventive health measures if they believe that they are actively involved in making choices and in implementing their own decisions. Consider, for example, adherence to a long term program for sub-clinical hypertension, which might include keeping referral appointments, coming back for recommended medical checkups, taking prescribed medication, and changing life-style factors like smoking, diet, and exercise. Feelings of personal responsibility deriving from internalization of prescribed behaviors should be extremely important in such instances, because adherence to the medical regimen cannot be monitored continuously.

Dieting is a especially good example, since patients do most of their eating under unsupervised conditions. Those who engage in self-monitoring and self-reinforcement appear most successful (Mahoney, 1977).

In assessing the basis and effects of expert and referent power in the physician-patient relationship, it is important to note that a patient is almost totally reliant on referent power as a form of social influence. Some health care experts feel, when expert power is exclusively relied upon by the physician, a real problem can arise. While typically lacking expert power, patients can often feel intimidated by doctors who tend to typify the ideal patient as someone who is able to assess symptomology with sufficient expertise to know which conditions he or she should present, and when he or she should present them to the physician. Some patients use the legitimacy of their sick role to extract attention and increased time from their physicians. Using sick role behavior may be a way of exercising legitimate power (Johnson, et. al, 1982:63). However, patients are most likely to use referent power in a patient-doctor relationship. They try to be likeable, admiring, and accepting of their physicians. Since patients who are seen as more likeable do get better health care (Lorber, 1975:217), this form of power is effective in obtaining important health-related outcomes.

In many circumstances, the family can play a pivotal role in determining not only whether an ill family member will receive care but, if so, how the nature of the care will be conducted. This is especially significant when the serious nature of the patient's condition removes the patient from the decision-making process. In such cases, the patient's family may be the best source for providing information concerning the patient's clinical history. Despite this, for some physicians, the members of the patient's family are viewed as intruders to be tolerated rather than as important people to be included. Physicians often feel that the family's presence complicates the picture. At all hours of the day and night, they ask questions, peek in on the patient, disrupt schedules, and offer suggestions.

Efforts to treat illness and promote good health can often conflict with behavior patterns and attitudes in the home. Thus, not infrequently, J.H. Marby (1964) has observed, difficulties may be encountered in coordinating the goals of medicine with those of the family:

As a result, some families may appear to be either indifferent or uncooperative because the therapeutic regimen prescribed has not taken a effectual place among interlocking family practices, values, and habit patterns (Jaco, 1979:77).

Health care experts suggest that the family, in one way or another, should be involved in the decision-making and therapeutic process at every stage of the member's

illness, from diagnosis to treatment and recovery. The use of referent power can become very important here. Ruth Purtilo (1984:261-262) notes that sharing information and decision-making power with the patients family is one way of helping them maintain their dignity. She says:

They [the family] may respond to a health professional's suggestion by saying, "That's something you can judge better than we can," [or not], but having been given the option of deciding will help prevent them from feeling completely disregarded when important decisions are made. Those family members who recognize themselves as part of a supportive context that also involves the patient and the health professionals are likely to offer more, receive more, and continue to keep a better perspective on what is happening.

Overall, interdisciplinary research involving the medical, social science, and related health professions suggests that referent power, with its emphasis on both the patient's involvement in decision making and the patient's health as a mutually desireable goal, should be the first choice among practitioners as a source of social influence in the physician-patient relationship.

Those who endorse a "patient as equal" model feel it is likely that contact with a physician who is using referent power can reduce anxiety in patients. By giving reassurance and satisfying the patients' stress-induced desire for interpersonal contact, a practitioner can alleviate fear and related emotional states (Rodin, 1982:61). This in turn may better enable patients to

attend to and learn the information being given.

The findings and analysis that make up the content of section two will examine what circumstances give rise to a particular style of interaction on the part of both the physician and the patient. Furthermore, the analysis will discuss what circumstances promote a challenging of opinion and mutual decision-making and what it means to the patient in terms of having a sense of control over his or her health. Questions such as the extent and conditions under which perceived control on the part of the patient is indeed beneficial will be investigated. Overall the analysis will focus on how and why the traditional and antielitist models can work for certain people under certain circumstances as well as specify the effects of the different bases of social power in the patient-physician relationship.

CHAPTER TWO

THEORETICAL FRAMEWORK

To assess power and social influence in the patient-physician relationship, I have used symbolic interactionism as a theoretical framework.

"Symbolic interaction" is the interaction that takes place among the various minds and meanings that characterize human societies. It refers to the fact that social interaction rests upon a taking of oneself (self-objectification) and others (taking the role of the other) into account (Meltzer, 1975:1). In regards to the patient-physician relationship, these "others" are mainly men - or women who have been trained to think according to masculine and traditional definitions of health, and how patients should be treated. This "scientific" perspective often views a person as a disordered body whose malfunctions are isolated from the rest of social life, with its prescriptions of appropriate roles and behaviors for men and women (Webb, 1986:183).

In the interactionist image, human beings are defined as self-reflective beings. Human beings are organisms with selves, and behavior in society is often directed by the self. As Meltzer (1975:2) states: "The behavior of men and women is 'caused' not so much by forces within themselves (forces, drives, needs, etc.), or external forces impinging upon them (social forces, etc.),

but what lies in between, a reflective and socially derived interpretation of the internal and external stimuli that are present."

In other words, people are presumed to be active and creative and self-determining; not passive recipients of outside forces. What is important here, concerning patient-physician relations, is that in many cases the patient is not allowed or is unwilling to be an active participant in making important health relevant decisions. When physicians operate under the "patient as inferior" model, patients often feel they are not able to exercise their own judgment about health care options and are reluctant to overturn traditional professional-client relationships. In other words, they are forced to remain "patients" in the literal sense - passive receivers of what others think is good for them. Thus, the fact that people are active, creative, and self-determining does not eliminate the power differences between doctor and patient, and may have no bearing on how relevant health outcomes are arrived upon. This is why an examination of patient's perceptions of power and social influence in the patient-physician relationship is so important.

Through the use of symbolic interactionism, "we want to know what the actors know, see what they see, and understand what they understand" (Schwartz and Jacobs, 1979:7). Instead of viewing patients only in the setting

of their face-to-face interactions with their physicians, they must also be seen in terms of their social and cultural experiences. As Freidson (1962:209) suggests, what goes on in the interaction process between doctor and patient may be influenced by the knowledge and attitudes in the lay culture from which the patient comes, and that lay knowledge and attitudes are likely to differ from professional knowledge and attitudes:

The separate worlds of experience of the layman and the professional worker are always in potential conflict with each other.

A similar argument is presented by Gerry Stimson and Barbara Webb (1975:5). They maintain that problems of doctor-patient communication should not be seen as purely problems of the attributes of the two participants but also as problems of contact between the lay and professional cultures from which each comes. Interaction, as a social activity, needs then to be expanded from simply the face-to-face contact of doctor and patient. There is a need to move away from a bounded microscopic view of the communication dyad and consider the doctor-patient relationship as a social process: the focus is then on the perceptions of the patient and on the interaction between the patient and those people (significant others, including the doctor) around him or her.

Mead's concept of the "process of communication"

becomes important here. According to Mead, it is through communication that the self arises, but he also maintains that it "is not simply a matter of taking in the communication, but one of interpreting the intended meaning (interpretation is usually based on what people "know" from their lay culture and from significant others). The group (ie. doctor-patient relationship) therefore, is conceived as a body of meanings which are products of interacting individuals (Meltzer, 1979:45). Though a sharing of meanings which develop in interaction, the individual and the group become part of a larger system, and both become, in the words of Cooley, two sides of the same coin. Rather than simply being a present condition in behavior, the group becomes a referent, a symbolic bond in the individual-society relationship (Meltzer, 1979:45).

As a result, this presentation of the data and findings attempts to describe the patients' vocabularies, their ways of looking at things, their sense of the important and the unimportant, and so on. More precisely, the data describes: how patients define the "patient role" and to what extent they perceive themselves to be active and self-determining; how patients perceive their doctor's definition of the patient role; what patients define to be the doctor's role; how patients define the ideal doctor-patient relationship (based on their expectations and that

of their lay culture); and how patients handle conflict that arises in terms of their perceptions of power differences and poor communication between themselves and their physicians.

Some social researchers maintain that it is very important that physicians exercise referent power in their relationships with their patients and be willing to share knowledge. As Peter L. Berger (1966:46) notes, "the social distribution of knowledge of certain elements of everyday life can become highly complex and even confusing to the outsider." He says most people do not possess the knowledge to supposedly cure them of a physical ailment, they may even lack the knowledge of which one of a bewildering variety of medical specialists claims jurisdiction over what ails them.

If the sharing of knowledge and the "process of communication" is to be possible within the patient-physician dyad, the participants, at the onset of the relationship, must have a clear understanding of their roles in order for cooperation to be successful. Joel Charon (1985:106) notes that taking the role of the other is basic to human cooperation. To cooperate means to know where the others are at, what they are doing, and often, what they are thinking.

To coordinate one's action with others demands a certain amount of understanding where others are going.

Cooperation at any level demands the simultaneous understanding of one's own acts and meaning of others' acts.

Coordination requires that each participant be able to anticipate the movements of the others, and it is for this purpose that men who are cooperating watch one another... anticipating what another human being is likely to do requires getting "inside" of him (Shibutani, 1961:141).

Thus, in the patient-physician relationship, there must be people role taking - understanding and anticipating each other's actions - if any kind of cooperation is going to take place towards the goal of healing. "If we do not role take we are doomed to keep bumping into each other, duplicating tasks, unable to adjust our own acts to other's acts - all of which of course, makes cooperation impossible" (Charon, 1985:107). According to many social researchers and health care experts, the true sharing of meaning and role taking that ensure a smooth "process of communication" is only possible in an equal relationship in which neither patient nor physician has more rights or privileges than the other. This kind of sharing and equality allow open discussion and mutual questioning and challenging of opinions. Through these processes, patients develop a sense of control over decisions regarding their health, and are in a better position to understand and act upon the recommendations of their physician.

CHAPTER THREE

METHODOLOGY

Ideally, data for a study of power and social influence in the patient-physician relationship would be gathered by direct observation of the everyday confrontations between physicians and patients. For a variety of reasons, observations were not feasible, the most compelling being the improbability of convincing a large and diverse group of physicians to grant access to their patient consultations. The ethical problems alone (breach of confidentiality) were sufficient to dictate a different methodology, namely qualitative semi-structured interviews that focused on the subjective experiences of patients. Since the actor's (patient's) point of view is of central concern to this study (and to qualitative sociology in general) it only made sense to employ a research strategy that takes this into account.

Support for a qualitative methodology in studying patient-physician communications comes from feminist research. For example, in 1977 Helen Roberts and Michele Barrett, working together on a sociological analysis of women's consulting rates with their general practitioner, took part in a workshop on qualitative methodology. They found the experience quite useful insofar as gaining an insight into the subjective experiences of women as patients (Roberts, 1981:7-10).

The actual interviews for this study were formulated following the basic outline of Merton, Fiske, and Kendal's (1954) The Focused Interview. The interviews examined the problems and areas of concern previously addressed. The actual interview questions, however, were not specified in advance. Utilizing Merton's steps for constructing a focused interview I developed an interview guide, setting forth the major areas of inquiry into the patient-physician relationship. The interviews themselves focused on the subjective experiences of patients in order to ascertain their "definitions of the situation." The array of reported responses to the situation (power and social influence in the patient-physician relationship) helped test the areas of concern and, as Merton, Fiske, and Kendal (1954:4) suggest, to the extent that it includes unanticipated responses, can give rise to fresh hypotheses for more systematic and rigorous investigation.

The focused interview was most appropriate for this study in that as a research technique, it goes one step beyond the open-ended questions as in a structured interview. In the focused interview, questions are also open-ended to provide flexibility and allow for unanticipated responses. But in addition "the focused interview allows flexibility in the order of the questions asked" (Bailey, 1982:201). Since questions were not written in advance, they were tailored to probe avenues of exploration that seemed to be yielding

information to problems in the patient-physician relationship. The flexibility resulted in questions that were really a long series of probes that investigate deeply into the respondent's mind in an attempt to discover their feelings and motives (such as patient's feelings of inadequacy or "reactance").

There is evidence to support the contention that unstructured interviews may be the best course of action when one is keenly interested in uncovering patients' perceptions in the patient-physician relationship. Stimson and Webb (1975:108), who combined interview techniques with participant observations of doctor-patient consultations, report:

We have used material on stories to illustrate one way in which the contact between the patient and the doctor is seen from the view of the patient. We found using our unstructured and sometimes unobtrusive techniques that much of the talk about doctors contains criticisms and reflects conflict in the patients' relations with their doctors which was not so evident from our surgery interviews and observations.

In order to retain and retrieve the information from the focused interviews, tape recordings were made. Tape recording allow me to concentrate on the interview without distracting the respondent by taking notes and still retain all that the respondent related. The presence of a tape recorder may have been somewhat intimidating to some respondents, however, the retention of vital information and the lack of distortion that tape recording provides.

far outweighed this potential drawback. Any other problems associated with tape recording were countered by taking notes, as soon after the interview as possible, about what emerged as meaningful and why.

It is generally thought that no project in any discipline can avoid the problem of a bias in selection of research area and method. The choice of problem area and methods for this thesis means that one side of the medical interaction - the patient - is emphasized at the expense of the other - the doctor. In 1975, Stimson and Webb (p.vii) suggested that "there is a paucity of research that deals with the patient as a person." Since that time, only a handful of researchers have studied the patient-physician relationship from the patient's perspective with the attempt to reformulate theories and ideas about the medical profession and professional-client relationships. Thus, I feel that the choice to study the doctor-patient relationship from the patient's point was warranted.

In writing about the interaction process from the perspective of the patient, I was interested in what people say they experience - their expectations, worries, likes and dislikes, and evaluations of themselves and their doctors. Everyday talk about doctors, like everyday talk about any other social group, is often critical. Lest any reader of this thesis feels that physicians are being

unfairly judged, he or she should be reminded that the perceptions of the people who contributed to this study are to be viewed in terms of what they indicate about the relationship between patients and their doctors, and not assessed at the level of specific cases of complaint.

SAMPLE

Seventeen subjects (seven males and ten females, and all from the Windsor/Essex County, Ontario area) were interviewed for purposes of this study. All subjects were of a lower to upper middle class background and were between the ages of 22 and 55. The method of sampling adopted was to divide an adult population into three categories of users: (1) recipients of frequent care, (2) recipients of infrequent care, and (3) family members. Each of these categories was composed of users who on account of their different experiences had unique attitudes towards certain "types" of physicians.

Interview subjects were categorized as "recipients of frequent care" if they had seen a doctor or a number of doctors counting five or more times in one year for one or more problems. The "infrequent care" category was defined by those patients who have visited a doctor less than five times in one year. "Family members" were those interview subjects who visited and consulted with a physician concerning the health of a close relative (i.e. child,

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mother, father). With regard to this study, "family members" were most frequently mothers who brought their children to a physician. In fact, all of the "family member" interviews were with women. This should not be too surprising when one considers that women consult physicians much more often than men. Roberts 1985:2) reports, "Women go to the doctor more than men... and they spend more time looking after other people's health than men do." All but one of "family member" interviewees told of their own experiences with physicians. This added significantly to the amount of data collected for this study and also serendipitously provided an interesting look into what some women expect for themselves in terms of treatment from their doctors as compared to expectations of treatment for their children. The findings on this point are recorded in section two.

The sample itself was a snowball sample. The initial interviews provided a first stab at what was going on in the patient-physician relationship. In this first stage, a few persons having the requisite characteristics (i.e. long and/or short term contact with a physician, either as an individual or as a family member) were interviewed. These persons were used as informants to identify others who qualified for inclusion in the sample. The second stage involved interviewing these people, who in turn led to still more persons were interviewed in the

third stage. The advantage of this type of sample was that as a researcher, I could use my own judgement about which respondents to choose and pick those that best suit the purpose of the study. At each stage, I attempted to be selective in choosing respondents of various ages who had similar and dissimilar experiences with physicians thus, maintaining a degree of sample variability.

It should be stressed at this point, that the sample used for this study is not intended to be representative of an entire population. It is, however, intended to be a subjective account of what some people are saying about the power dynamics of the patient-physician relationship. It is this author's hope that these accounts will provide the readers of this thesis with an understanding of power and social influence in the patient-physician relationship from the perspective of those who are most affected by, "good doctor" or "bad doctor" experiences - the patient.

THE INTERVIEW

The interviews were conducted at the respondents' homes between May 3, and June 30, 1987 with the exception of two interviews that were conducted on campus at the University of Windsor. The duration of the interviews varied widely and ranged from about a half hour to one and a half hours with the average being about forty minutes. It was felt that the interviews were long enough to allay

anxiety and dispel any efforts by the respondent to gloss over his or her problems. Certain factual questions concerning age, occupation, and educational background of the respondent, and some basic background questions about his or her physician(s) were purposely put first in order to disarm the respondents and ease them into the interview. To accomplish the objectives of this study, questions which gave equal opportunity for favorable and unfavorable responses were asked about many aspects of the interaction process between patient and physician.

The advantage of the snowball sample for this study was that by the second and third stages, the task of dispelling anxiety and establishing rapport with new interviewees was made easy by the fact that each of these respondents personally knew someone who had been interviewed before them. Thus, certain concerns of potential interviewees such as "is what I have to say important enough?" or "how long is the interview?" were addressed before initial contact by this interviewer. This meant that I need only repeat the explanations and assurances of the new respondents acquaintance in order to establish a quick rapport. For the most part, by the second and third stages of the "snowball," respondents were very much at ease and quite cooperative.

CHAPTER FOUR

DOCTOR AND PATIENT TYPES

The purpose of the interviews was to ascertain the attitudes and perceptions of patients to the various styles of interaction with regards to power and social influence in the patient physician relationship. The study was also interested in how patients reacted following a negative or positive experience with a particular physician. What I have done in analyzing patient responses, was to create a typology of doctors and patients that will help to explain how and why participants in the patient-physician relationship behave the way they do. The doctor typology is in effect, a list of all the characteristics that patients perceive about the doctors with whom they interact. By the same token, the patient typology presents the different characteristics that patients perceive about themselves. It was felt that by formulating a typology based on responses from interview subjects, one could get a better sense about what power and social influence mean to patients as they interact with "types" of doctors.

DOCTOR TYPOLOGY

It is necessary to stress that the doctor types presented here are based on responses from interview subjects and thus, they represent what patients report

about their doctor. This author chose to formulate a doctor typology based upon patient perceptions; however, this typology should not be considered as the ultimate system for labeling doctors. Indeed, one can be certain that a doctor who is reported to exhibit certain "good doctor" or "bad doctor" characteristics as evident in a particular interview, may not be labeled the same way by all of his or her patients. Nevertheless, the recorded array of responses from patients about doctor "types" gives us important clues about what makes physicians "tick" as well as what characteristics and circumstances during interaction will promote or impede a patient as inferior or a patient as equal model of communication.

As reported in the review of the literature, there are two forms of interaction that dominate the power dynamics of patient-physician relationships, namely the traditional or new antielitist models. Thus, in creating a doctor typology it was necessary to work with in these models. From the various responses gathered in this study it is appropriate to define four doctor types: the "Authoritarian" and "Doctor God," who operate within the traditional mode of interaction, and "Doctor Nice" and the "Referent Doctor," who operate under the antielitist model.

THE AUTHORITARIAN

Characteristics of the authoritarian are generally as follows: They tend to be heavy handed in the use of expert power as a means of influencing their patients. This is usually coupled with a lack of sympathy and/or empathy as perceived by the patient. Authoritarian types are generally labeled as unlikable, nonetheless, most patients perceive them as competent. What is uniquely interesting about the authoritarian is that their apparent inability to convey a genuinely caring attitude is excused in light of the fact that they are competent skilled technicians. More often than not, the authoritarian is a specialist, and others (friends of the patient, nurses, or more commonly, the patients family physician) are usually responsible for instilling in the patient a sense of trust in the physician's competence. Since the authoritarian often comes recommended, they often do not have to deal with patient challenges, or in many cases, they feel they should not have to deal with patient concerns and challenges. Information sharing in this relationship is typically minimal. However, patients put up with this style of interaction because of the perceived expertise of the physician. The following quotations illustrate these points: (Readers should note that throughout this thesis the abbreviation "I." signifies the interviewer's questions).

Doctor M. he's a bastard he really is. The nurses don't like him, they say he treats women like cattle, and he really does. When I was in to deliver J. (patient's son) I remember I was sleeping and he started shoving something up between my legs without even waking me. I mean I woke up with this hook between my legs, like it was just ignorant. He doesn't acknowledge you or nothing. And I got the impression like he thinks he's doing me a favor. He wouldn't even look at me. He zeroed in on between my legs and that was it. It was F. (patient's family doctor) who came in and talked to me while this guy was doing his thing.

- I. Did you voice your concerns about Doctor M. to your G.P.?

Oh F. knows I don't like him but he says he's good, he's the chief gynecologist. Like I know Doctor M. is good, I don't like his bedside manner, but I know he's good. Well, to be chief of gynecology you have to be good, like he cares about his job, but he doesn't care about what your thinking, he couldn't care less.

Another male patient has this account:

Well I had a terrible experience with C. Doctor C.'s an orthopedic surgeon. I met him through S. (chiropractor) because S. said he was good. So I went to him, but he's got a terrible bedside manner, he's ah...like I'm sitting there with a lot of pain with my knee and he goes "Oh we're gonna hafta get the fluid out" and he just, he has this long needle about a foot long, pulls it out and sticks it in my knee and like I'm in intense pain, and he's sucking out the fluid and I'm going "ahhh!" and he going "why don't you just keep it down, what's wrong?" And I say "Hey!, the fuckin' thing hurts, it's as simple as that," and that's exactly what I said to him. But I shook it off, and he shook it off. But as I saw him through time he's...he's real arrogant, a real prick actually, but he's damn good, like I say; my knee, I knock wood when I talk about it, but it feels good.

Authoritarian types are not always reported by patients to be unlikable. The circumstances under which a patient interacts with a physician can play a critical

role insofar as how important such factors as a "good bedside manner" or sharing information and power are concerned. To be sure, patients can have good experiences with authoritarian type physicians when they enter the relationship with clear expectations that the physician will use his or her expertise in prescribing an appropriate treatment or procedure. Consider the following response from a woman suffering from an inflammation on her tongue who when to visit a dermatologist recommended by her family doctor:

When I got there I didn't care what he said or what he gave me. I didn't care if prescribed dynamite, just as long as it cleared it up. My mouth was so sore.

DOCTOR GOD

The second of the traditional doctor types is whom I refer to as "Doctor God." Patients state that this type of doctor displays an omnipotent attitude and is highly sensitive to any challenges to his or her professional diagnosis or directions. This sensitivity significantly hinders sharing of information and mutual decision-making. This doctor type relies exclusively on expert power and the legitimacy of his or her professional role during interactions with patients. Doctor God types are deemed unlikable and incompetent by patients who perceive these doctors to have a total lack of concern for their best interests.

A woman explained her dismay with a Doctor God type who ignored her questions and concerns about the chance that her granddaughter could have contracted encephalitis. The doctor, a pediatrician, had earlier diagnosed the child as having tonsillitis and admitted the child to the hospital for treatment and observation. The respondent reported that the child was not displaying what she regarded as typical symptoms associated with tonsillitis as she was vomiting heavily and one of her eyes had begun to deviate, furthermore the child was not responding well to treatment:

I asked him "could it be encephalitis?" He disregarded my questions completely, he said "don't get hysterical on me." I said "I'm not an hysterical grandmother and I've had a lot of experience with children." He said "there's no reason to look for encephalitis."

I. Why do you think this doctor acted this way?

My own personal opinion? Well, he seemed to me indignant that I would suggest such a thing, and after all he was the specialist.... the nurses assured me that he was a good doctor and I allowed myself to be soothed by this until this day but I became alarmed that he did nothing....He said "if you think something's wrong with her eye then you can take her to an ophthalmologist," which I did do.

As it turned out the child was diagnosed by the ophthalmologist as suffering from encephalitis. She was treated and recovered in a London hospital.

While typically a specialist, Doctor God types do not always come recommended. In fact many of the Doctor God types in this study were doctors that patients sought

out on their own or just happened across. in their search for treatment. Thus, one can speculate that some Doctor God types may in fact be authoritarian types who did not have the benefit of a recommendation from a significant other in the patient's life. Subsequently, Doctor God types are quickly condemned for inappropriate behavior and for failing to meet the expectations of their patients who often have nothing else to build a basis of trust in these physicians outside of the nature of the interaction itself. The following example illustrates this point. A woman who had reinjured her back in a fall only days after a spinal fusion operation happened across the doctor who was filling in for her vacationing family doctor:

This doctor said "you have a brace on." I say "yeah." He said "well you can't hurt your back." I say "if I can't hurt my back than why am I in pain?" "Well you can't hurt yourself" he said, and wouldn't check my back.

I. Did you insist that you were in real pain?

Oh yes, I said "don't tell me I can't hurt myself," but he wouldn't check me, so I said "get me X-Rays." That was not necessary he felt.

I. How did you feel about this?

Angry. I just expected more from him, eh. He treated me like everything was emotional.

DOCTOR NICE

This particular type of doctor is the most common type of doctor that patients interact with. Typically a G.P., (less frequently a specialist in terms of recorded

responses in this study), Doctor Nice types use expert power in combination with some of aspects of referent power. They are generally sympathetic but not always empathetic, that is, they do not readily identify with their patients insofar as understanding the reality or the meaning of a condition from the patients perspective.

Patients report that Doctor Nice Types are "good listeners" and are likeable in spite of the fact that they are often rushed and can not spend the desired amount of time that a patient expects or would like. For the most part they share information with their patients when asked direct questions but do not usually volunteer information. This type of doctor is apparently open to challenges at least in terms of listening to the patient. However, mutual decision-making is minimal with the physician preferring to limit the discussion of options and choices for the patient during interaction. Their level of competence can be perceived as either high or low, this is usually dependent on the patient's expectation for a cure.

A male patient reports:

You know, he was bubbly at first. You know, like he could communicate, his communication skills were good but he didn't do anything for me, that's what it basically boils down to.

The following two responses are further examples of interactions with Doctor Nice types:

I didn't know much about him at first so when I went to see him I was kind of nervous, kind of scared, I didn't know what to expect from him. But as soon as

I got there he kind of introduced himself, he's a quiet man right, he's somewhat quiet. But the first day I went there he made me feel like I knew him for years and years, like we just sat down and talked. (Male patient about his specialist).

And:

He treats me like I'm a somebody not just a nobody, and he knows I have at least a little something upstairs. Like he can talk to me about what he's doing, I'm a person not just another number...he respects my opinion and what I'm doing.

- I. How is he at sharing and volunteering information with you?

Really good, yeah super, he tells you everything and anything you want to know. Well, not everything, you want to know, it's what you need to know, you know?" (Female patient about her pediatrician).

THE REFERENT DOCTOR

The "Referent Doctor", the second of the antielitist types, is the closest to what patients define as the "ideal type" and epitomizes the patient as equal ideal in doctor patient relationships. Relying on referent power during interactions, Referent Doctor types are perceived to be good listeners who display a sense of sympathy and empathy in identifying with their patient who define them both as likable and competent. Patients report that they appreciate the manner in which Referent Doctor types share and volunteer information. That is, information transfer is not limited to diagnosis and recommendations. Referent Doctors will initiate discussions with their patient about the risks of a certain procedure, side effect of

prescribed drug regimens are explained, and options and choices concerning treatment are explored. The physician encourages a high degree of mutual decision-making where there is a sharing of knowledge, a challenge of opinions, open discussion, and mutual questioning. The following two quotations are a selection of responses about referent doctor types:

I've had a really good relationship with my doctor. He cares! He thinks and cares about you. He thinks about you before he makes any decisions on what kind of treatment I get. He's thinking of my welfare. You're not a number or anything like that. He's looking after you as a patient. (Male patient about his orthopedic surgeon).

And:

Doctor H. is excellent. He's very thorough. He explains everything to you, what he's doing, he tells you what he finds, and what he can do about it. I said to him "look I'm going to tell you exactly what my problem is, and I quit going to the last guy cause all he wanted to do was give me pain pills." So I told him about my back problem, and he just really listened...he's not a pill pusher at all, and I like that about him. He tries to find out why your having a problem and he tries his best to correct it. (Female patient about her G.P.).

There does not appear to be any difference in the frequency of reported Referent Doctor types when comparing general practitioners to specialists. This is somewhat interesting when one considers that in this study most of the reported "Doctor God" types are specialists. Therefore, it appears that specialists tend to dominate the extremes of the traditional and antielitist models in doctor-patient relationships.

EXPLAINING DOCTOR TYPES

Erving Goffman (1959) has suggested that managing and manipulating impressions, and conveying a competence one would like to be believed and accepted, characterizes interactions where participants desire to be successful. Individuals and groups maintain fronts conveying certain impressions and covering up less desirable aspects of personality and behavior.

Though managing impressions and role playing are basic parts of the sociological drama, they may be more obvious where participants perceive a potentially critical and condemning audience. This is obvious when the audience (patients) has high expectations for others (doctors) and expect if not demand, displays of competence, especially when those assumed to be competent control the situation and act or make decisions affecting the well being of others. The affected parties then look for cues and indications of personal and or collective (institutional) competence and practitioners organize a carefully managed presentation of self to create and sustain a reality of competence. Patients look for competent advice and assistance and want to believe they will get it. Conversely, physicians want to convince those they treat that they are indeed competent and trustworthy, and that the patient can confidently allow them to diagnose,

prescribe and intervene to affect the patient's condition (Haas and Shaffir, 1977:72-73).

It is interesting to compare and contrast doctor types on this point. It seems that traditional doctor types are less concerned about creating a reality of competence, assuming that their patients will view this as a given during interactions. On the other hand, antielitist types use techniques such as being attentive, answering questions carefully, and trying to convey a genuine sense of concern for their patients. These techniques instill in a patient a trust in the physician's competence. But traditional types of doctors rarely seem to use these techniques and, as patients report, (specifically with "Doctor God" types) can actually cause patients to deem them incompetent by virtue of their poor behavior.

What mechanisms allow physicians in their institutional roles to carry out behavior they themselves would probably condemn if these occurred outside the institution? One reason may be that such physicians may be receiving false feedback concerning their own worth and expertise. Because of the resources they control, physicians may find that their ideas and opinions are readily agreed with and that there is no need to create a reality of competence. David Kipnis (1974:96) notes:

Public compliance may lead the powerholder to believe falsely that his ideas and views are

superior to those held by other persons, when in fact compliance is based not on the superiority of his ideas, but on the superiority of his power. In addition, the powerholder's view of himself may be further distorted by the flattery and well wishes he receives from the less powerful who are anxious to keep in his good graces. If it is not recognized as such, this flattery may also contribute to the powerholders ideas that he is something special.

Another plausible reason may be that some physicians believe that the institution of medicine has granted them absolution for their acts, and that they are "only doing their duty," as they were trained to do. Studies of professional socialization (Becker et. al., 1961; Bloom, 1973; Olsen and Whittaker, 1968) have shown how trainees, such as medical students, adopt a professional image as they proceed through the socialization experience. These studies show that the socialization experience involves learning specific skills and techniques as well as taking on an occupational culture including a new or altered identity. Haas and Shaffir (1977:72) note that medical students leave the lay world and join a marked different one.

The separation involves an alteration of biography, status and unity. Professional, particularly medical student, socialization, is traumatic because the separation includes not only leaving one's past (lay culture) but moving to a position and role accorded great power and prestige.

Thus, professionalism, as observed through the eyes of the respondents in this study, can involve the adoption and manipulation of a set of symbols and symbolic behavior to create an imagery of competence and the separation and

evaluation of the profession from those they serve. In other words, for some physicians, the goals of a patient as equal model in doctor-patient communication can conflict with their background and understanding of a physician professional role.

PATIENT TYPOLOGY

From the array of responses from interview subjects about their experiences, one can define four distinct interactional types: (1) the "Passive Patient," (2) the "Active Patient," (3) the "Demanding Patient," and (4) the "Consumerist Patient."

THE PASSIVE PATIENT

Characteristically, the "Passive Patient" is inactive during the interaction process with a physician. They do not usually seek information on their own; if so it is minimal. Such persons like to "chit-chat" with their physician but do not always define this as an important part of the interaction process, although some report that it can help to put them at ease. Passive Patients do not ask many questions during consultations, instead they prefer or expect the physician to use their expert power in prescribing an appropriate treatment or procedure. Trust in their doctor's competence is generally high, where "good doctors" are described as someone who can

solve or cure the patient's problem. The following quotation is from a male patient about his specialist:

And then one day I asked him, you know, "what exactly did you do?" because, you know he doesn't talk much, right. So I asked him, he sat down and showed me exactly what he did, where he made all these incisions, and he also showed me/...

I. This was after the operation?

This was after the operation. And he said what could happen if my colitis acted up again, like as far as removing all your bowel and like even removing part of your ass, right, stuff like that. But he did a thorough job, he really did.....at first I didn't know what the hell was going on, right, but later when he started to cue me in a little bit, and when I started asking some questions it started to fit in, it was like a puzzle almost. I expected to get cured. I didn't expect it to take five years, you know. I don't know, I had high regards for the guy.

It should be noted that some Passive Patient types can become more active during interactions with their physicians if they feel their problem is serious enough to warrant them becoming more involved. It is also necessary to mention that Passive Patients can sometimes be persons who report that they are normally quite active during consultations and examinations but become inactive in situations such as they are experiencing pain, or they feel their illness is not so serious that they need to receive and share information with their physicians. A woman who was suffering from a form of throat infection and went to her doctor for penicillin had this to say:

I told the doctor I had stopped taking calcium and he gave me a pamphlet to read to help me understand how some women need calcium so that maybe I'll

change my mind.

I. Did you discuss taking calcium with him?

No. I felt really sick, and I just wanted to get this thing over with. I wanted him to say, "yes take penicillin, goodbye." But meanwhile, I also needed a booster shot and he decided I should get it while I was there. You know, I didn't want to get it then I just wanted to go home. But he gave me the booster shot and I didn't want to get into any meeting.

THE ACTIVE PATIENT

Active patients expect a high degree of interaction with their physicians in terms of information transfer. This patient is an information seeker who usually goes to the physician armed with a list of questions as well as some kind of self diagnosis based upon literature they have encountered. Perceptions of a physician's competence usually coincide with the degree to which the physician recognizes and allows the patient to test and use the information they have gathered. The physician who encourages the Active Patient to communicate their knowledge and concerns where decisions affecting that patient's health are to be made are defined as "good doctors." Other types of doctors are described as "bad doctors" or "just O.K." Obviously it is antielitist doctor types who works best with the Active Patient.

A woman who, is an Active Patient type, had the following comment report about her general practitioner:

One of the things that really characterizes my relationship with Doctor M. is I feel he really respects that I care enough to become knowledgeable about what's wrong with me or my children, or whatever... and he really explains what's wrong, like he really feels that I'm bright enough to understand, and he tells me, and I really value that. He said to me, you know... he found out about a lot of stuff from me about it because I really read and read and read everything about cleft palate problems.

THE DEMANDING PATIENT

This interactional type combines the unique qualities of having little concern for gathering information or with mutual decision-making while at the same time placing high demands on a physician's time. Demanding Patient types enjoy the socializing aspect of doctor-patient interaction and value the physician who will listen to their problems. They define most doctors as competent, but are most satisfied with the doctor who will take the time to listen to them. They are generally compliant with the doctor's orders, but again, they will adhere to a particular recommendation more readily if they felt the doctor did not rush them and listened to them during the consultations and displayed a genuine sense of concern. The following quotation is characteristic of the Demanding Patient type:

I feel that even if you're just going in for a physical, the doctor should be generally open and courteous with you, so you're not just another file in the file cabinet, that sort of thing. Now the doctor I just went too, he was interested in what I'm saying. He's got a lot of patients, but he still, after looking at my file, asked me about how

I was doing. I heard he was good, and for my standards I thought he was very good.

- I. How would you describe the ideal doctor-patient relationship?

Well, one where there's open communication. One where there's real concern, one where he's not staring at his golf clubs in other words. The relationship I have with this doctor is what I'd describe as ideal. As far as the patient goes, if you believe your doctor is right then you'd best follow his advice or you've wasted your time. (Male patient about his G.P.)

THE CONSUMERIST PATIENT

This "type" of patient has most of the interactional characteristics of the Active and/or Demanding Patient type. The important difference here, however, is that unlike any other patient type, the consumerist will not simply label a physician "incompetent" or "unlikable" if he or she fails to meet the patient's expectations, but will instead shop around for a physician who does measure up to their standards:

Well I feel if a patient can't talk to her doctor and have a one to one, then she'd better look for another doctor. I mean you have to feel comfortable with your doctor. I think that after two or three visits with a doctor and you're not getting what you want, he's not going to change, then you should go shopping for someone else. A doctor can give you the best surgery around, but if he doesn't have a good bedside manner, umm, I think you need to have that too, and I think you can get both.

It is important to note that, not unlike doctors, patients do not always stay within the boundaries of one particular "type" of character. As alluded to above,

patients can adopt characteristics of other interactional types dependent upon the nature of their condition or "how they feel" at the time of an interaction with a doctor. It is also important to note that most of the patient types have very similar ideas about what the ideal doctor-patient relationship should be like. The majority of the interviewees report that all or most of the characteristics that define the patient as equal model constitute their description of an ideal relationship with a physician. However, this author has found that such ideas, and what patients actually experience during a consultation with their physicians, are not always in agreement, nor do they always have to be for certain patients to report of "good" experiences with their physicians.

THE THREE STAGES OF INTERACTION

Nearly everyone goes to see the doctor at one time or another and nearly everyone is at sometime or another a patient to a doctor. There are many problems for each participant in managing the interaction as a social activity. Life, as Goffman (1959:243) has said, may not be much of a gamble but interaction is. For example, for the doctor there may be problems in eliciting what he feels is adequate information from the patient. For the patient, there may be problems in getting across to the doctor his

or her view of what the problem is and what he or she feels should be done about it. I will therefore treat the patient-physician relationship as a problematic encounter.

Interaction between doctor and patient can be seen as a special type of social encounter in which one person seeks information or advice from another. It is akin to focused interaction (Goffman, 1961:7) insofar as both parties sustain for a time a single focus of attention. Interaction with a doctor is distinguished from everyday conversational social acts in that (1) it is geographically and temporally inflexible: interaction usually takes place at a certain place and at a certain time; (2) there is specificity: the advice will be the reason for the interaction - other topics may be raised but only incidentally; and as Waitzkin and Stoeckle (1972) point out, there is usually a competence gap between advise giver and advise seeker.

Gerry Stimson and Barbara Webb did a study of doctor-patient interactions conducted at the Medical Sociology Research Center, University College, Swansea. They extended the social activity of consultation temporally and consequently spatially. They included in their study, actions outside the face-to-face contact of patient and doctor, but with reference to that contact. Using Stimson and Webb's study as a guide, I have divided the process of interaction between patient and physician

into three stages: the stage "prior to the interaction" which includes the expectations of the interaction, and the preparation for the interaction; second, the "face-to-face interaction" of patient and doctor when the actual interaction took place, which includes the performance of patients in presenting their self and their problems, the strategies of interaction used by patients and physicians in regards to the use of power and social influence, and the expressive and communicative aspects of the relationship; and third, the period "after the interaction," during which the patient makes sense of what happened, reviews the consultation and the doctor's actions, and makes his or her decisions about treatment, and appropriate course of action.

CHAPTER FIVE

PRIOR TO THE INTERACTION

That someone has decided to consult a physician implies that they have some anticipation or expectation of what the doctor will do; at the very least, an expectation that the doctor can take some action on their behalf. It is necessary to consider the prior anticipations and expectation of the patient in the period leading up to consultation because these provide the initial orientation to face-to-face interaction with the doctor and may consequently influence the course of the relationship.

It is assumed that when a patient has decided to go to the doctor, that person has come to see a visit as appropriate for their problem. However, from the material recorded in this study it is apparent that people do not always know when they are ill or not, or if they are ill what actions should be taken.

I have found that "others" may help a person define what problems call for medical attention, as well as offer advice on what actions the patient should take. The importance of others has been stressed by Davis (1963:168):

...a considerable portion of the individuals health and illness experiences takes place in locales and with the persons far removed from the guidance and control of institutionalized medical authority - in the home, at work, with kin, friends, neighbors and others within the person's routine orbit of existence.

It appears that advice-giving can play a crucial part in the decisions surrounding illness. People may be told that they "ought" or "should" go to the doctor, "challenge" their doctor, or "get a second opinion." One male patient reflects:

My friends were telling me to get a second opinion, so I talked to my family doctor and then it took me a long time to say to my Doctor L. there, (specialist) to say "hey, you know, I want to go for a second opinion." But then, you know he said, "L., you know what you want to do, and it's good to get a second opinion, I don't blame you at all."

The patient then goes on to say:

But then all these nurses and that, they were telling me "he's one of the best, he's one of the best," and I said "yeah, I know, I know," so I said forget it, I'm not going for a second opinion, cause well, I respect the guy and, you know, I had a lot of trust in the guy, I really do and I respect the man a lot....I mean. I never thought he couldn't perform this (operation) well, it was more everyone else telling me what to do, like get a second opinion, instead of me just saying, "hey I've known him for such a long time, he's a good doctor." And that's what I finally said, "I'm in your hands," you know, "do whatever you think is right." And that's exactly what he did.

This example points out that some doctors can have a real power advantage over patients when that doctor comes recommended or when "others" who share a similar professional role act on the physician's behalf to instill in the patient a sense of trust in that doctor's competence. Patients often surrender a big part of their potential power to influence a physician or to take control of their own health by forfeiting their right to challenge, shop around, or get a second opinion. In the

above case, the patient, who presented himself to be a Passive Patient type, was pressured by his friends to be more of an active consumerist. However, friends, who are indeed significant others, usually do not have the legitimate or expert power to be able to influence the patient. On the other hand, relative strangers (nurses in the hospital where the specialist works) by virtue of a shared professional role with the physician, are able to significantly influence the patient and can, as the above example shows, make patients compliant and accepting of their physicians.

With further regards to advice-giving, reference may be made to other people's experience with a similar problem, as a comparison, or to what is known to be "going around at the moment." Again, such reference can have a critical effect upon a patient's expectations about interactions with their physicians:

I used to tell him all the time about people I've met and talked to and tell me about people who have Crohn's disease and they do this and they do that. Like I heard of this guy who's got colitis and he's taking this pill, he told me the name of it and I go up to the doctor and say, "Hey doc, what do you think of this pill here? This guy takes this pill and he doesn't have pain, he doesn't have diarrhea, get me on it."

For the patients who do not seek advice from others prior to interaction with a physician, many report that they should be able to judge for themselves the seriousness of their problems, and that doctors expect

them not to consult over trivial matters:

Sometimes, because my parents don't speak English and stuff, I gotta be "Miss Interpreter" for them, so you gotta listen carefully and you gotta ask questions. But it's a pain because I gotta be the in-between-person and I hate being the in-between-person, so even when it comes to me I, ohh, like I don't want to feel like I'm pestering anybody, that's just me, I hate pestering people or bothering people, it's like "don't worry about it."

Another female respondent states:

Well my problem is I don't always go to the doctor for a yearly checkup like a person should....I usually go when I have two or three things I want to have checked out.

The second response indicates that some patients may actually "save up" symptoms or problems before they feel a visit to the doctor is warranted. Patients (most commonly Passive patient types) can surrender power to physicians by limiting their questions and general activity level during interactions. Thus, physicians are often given an advantage in the power and social influence aspect of the relationship by patients who feel that their problems and questions are needless infringements on a doctors valuable time. Consultation is not therefore always an immediate solution to a patient's uncertainty about a particular illness or problem.

In most cases, the decision to consult is reached because the doctor is seen as being able to take some action on the patient's behalf. The doctor can act in many ways. As Stimson and Webb (1975:21-22) point out, doctors provide services that the patient is unwilling, or

believes is unable, to provide for himself or herself: specialist information about physical or psychological problems, emotional support, and access to valued resources, including treatment. As I will point out in detail later, the doctor's power to provide these services means that they have great control and influence in the contact between themselves and their patients, although the patient too has ways of exerting control and influence. However the element of uncertainty in the decision to consult, and the uncertainty that the person usually feels about their own medical condition, adds to the control that a doctor can exert.

Before going to see the doctor, patients think about what is going to happen when they are in the doctor's office. Anticipating the encounter, and in particular, anticipating the possible problems that may arise, allows the patient to prepare his or her part. Preparation means that patients go over in their minds what they are going to say and how they are going to act when they meet the doctor. As one male patient stated:

By now I pretty well know the line of questioning, you know, what they're going to be asking. So I try to prepare myself by keeping notes of things that happened to myself and trying to remember dates of when I was last sick.

One of the problems that maybe anticipated by the patient is that being able to remember all that he or she intended to say to the doctor. For example the doctor

may be perceived as rushing things, as this woman reports:

I like to go in, sit down, tell him what's wrong and leave there having all of my questions answered, and not saying "gosh I forgot to ask him this" or "I forgot to ask him that."

I. Have you ever left his office in that state?

Oh, constantly. I get there and he's always in a rush, in and out of the room. You know, "Hi how are you?", blah, blah, blah. And you're going "ahhh" like that, and he's gone. And you walk out of there and say, "gosh I forgot to ask this, I'll have to ask him next time I go, and then the same thing happens. It's like he's so busy.

By preparing, the patient-to-be can try to make sure that all the important matters are remembered and discussed with their physician. For some people this is an active, well thought out practice:

I like to bring a list of questions and usually check things off once he's answered it, and write down the answer whatever it is... So I know for sure, and I don't forget to ask things.

Another female patient had this account:

The patient should have some kind of outline before they go to the doctor. I bring a list of questions if I know I'll have a lot of questions, because sometimes you'll go home and think "oh, I should have asked him that." So if it's other than just a general checkup I think you should have a list... If you don't tell the doctor what's wrong he's not going to know, he can't tell just by looking at you... and a list helps me remember. You know, sometimes you get nervous, so you can just glance down and your questions are there. It makes me feel like my visit hasn't been wasted.

We see once again that the circumstances surrounding the patient's decision has a direct impact on their behavior. In the above case the decision to bring a list

of questions to discuss during interaction was dependent upon the patient's perception of the seriousness of the problem. For purposes here, it is sufficient to point out that these and other less consciously thought-out ideas become part of the framework of face-to-face interaction.

It was found also that information gathering prior to a consultation with a physician can provide the foundation to the interaction process once a patient enters into a relationship with a physician. Many patients report that information they have sought outside of the patient-physician relationship made them identify symptoms more readily and gave them a greater awareness of the treatment options available to them. These patients stated that by becoming more informed they felt less anxious about their problem and less intimidated by the physicians they interacted with. One woman states:

There is a technique called bibliotherapy, where when you have something wrong it's therapeutic to read, read, and read everything you can get your hand on. And for that period with my daughter, I read everything I could get my hands on on her specific problem. That's how I deal with the unknown, it becomes known. And once you know it you start to cope.

Information gathering, as a strategy for exerting power and social influence, and the extent to which patient report that it gives them a sense of control over health related outcomes, will be explored in greater detail in Chapter Six.

Stimson and Webb (1975:30-31) claim that

"expectations" about the interaction and action vary in the concreteness with which they are held or expressed. For example, some people do not expect to have to define their expectations; they may have the idea that in some way the consultation as social interaction will take place and that the doctor in some way will be able to act for them, but cannot be more specific about this. They suggest that some people will maintain that it is not their place, as patients, to predict what will happen. This researcher found this claim to be quite true. One woman who when asked what she expected from a consultation with a specialist that was recommended by her family doctor, had this to say:

I go to this office and the guy sits me down and says, "So why are you here?" I said, "Well, I guess you're supposed to tell me...hey, I just follow doctor's orders, I'm here." So he sent me for some more tests.

On the other hand, statements made by some people provide examples of more specific expectations that the doctor is expected to take effective action on the patient's behalf. When asked what they expected the physician would do, some people replied in the following manner:

The doctor should familiarize himself with your record, and then to me he should listen to you tell him whatever you think is wrong. He should listen at first. He should make me be able to understand what's wrong with me and why I'm taking what I'm taking. He doesn't have to go into any great medical details, that I probably won't remember anyway, unless I ask. (Male patient about his G.P.)

I expect him to treat me like a person, not a number, and be willing to spend as much time with me as ...you know, if I have any questions he'll take the time to answer them. He's a good doctor and he's a nice person. But I feel like I'm on an assembly line and he's a dispatching agent. (Woman about her G.P.).

I expect him to know what's wrong with her (two-year old daughter) and for him to fix her. (Woman about her pediatrician).

When one begins to analyze patient responses it becomes clear that there is a strong link between prior expectations and how the power relationship between patient and doctor develops during face-to-face interaction. Actual events during the interaction may throw previously held notions of what might happen into sharp relief. Patients may only be able to define what their hopes of the relationship with a physician would be like in light of what actually evolved during their encounter. Thus, for some people, it is only in retrospect, that they come to understand their own expectations.

C

CHAPTER SIX

FACE-TO-FACE INTERACTION

Two themes guide the analysis of face-to-face interaction - strategies and negotiation.

During face-to-face interactions, both patients and doctors are essentially faced with the same problem (although I concentrate on the patient). This problem is self presentation. As in all interaction, the conscious and unconscious presentation of the self affects the behavior of the other and calls forth a reaction from the other. Stimson and Webb (1975:37) note:

In the consultation there is the problem of the outcome that is desired by both actors. People do not hand over all control and decision-making to the doctor merely by becoming patients. The presentation of the self can be used as a strategy. The aim of the strategies used by both patient and doctor is to attempt to control and direct the consultation along their own desired lines, to persuade the other to recognize or accept a particular perspective on, and orientation to, the problem that has been brought. Seeing the consultation in terms of each actor trying to influence the other brings in the concept of negotiation. For, far from the outcome of the consultation being determined only by the problem that the patient brings and by the diagnosis of the doctor, the outcome is a result of the mutual interaction.

Strong and Davis (1972) have noted that with regards to patient-physician interaction both doctor and patient can accept or reject the other's categorizations. The diagnostic outcome of the interview is therefore continually "negotiated." As referred to earlier in the examination of doctor types, we see that doctors use a

variety of techniques to maintain their status as experts, ranging from gentle reassurance to cantankerous responses, particularly when faced by patients' "loss of faith" in their competence.

Negotiation is a "process." That patients and doctors both use strategies to influence each other does not mean that one or the other is going to be successful. As Stimson and Webb (1975:38) stress, the concept of negotiation means that we see the outcome as a result of their interaction and the strategies they have each adopted, rather than as determined solely by the facts that are brought in the application of skills that the doctor has.

As I have pointed out earlier, most patients anticipate the interaction and often prepare strategies. Where the doctor and the illness condition are well known and the patient feels certain of the interaction and able to predict its possible course, one can suggest that the presentation of control and influencing strategies may have less of a persuasive content and the effort may be concentrated on reinforcing a common understanding and in following the usual pattern of activity:

The doctor asked me what was the matter and I explained to him how I felt generally blah, and he checked me over. I explained to him I felt sick and I've experienced this type of sickness before and it requires penicillin and he just kind of commented positively, approvingly. I told the doctor the kind of penicillin I wanted because it is the one I like

best. And he said, "O.K., you can take that."
(Female patient about her G.P.).

Patients report that they often feel that a doctor's behavior and recommendations are inappropriate and tactics may then be used by the patient to dissuade the doctor from the routine:

Like I've been going there a dozen times over the past three years and not once has he recommended any medication, any treatment, anything whatsoever, and this is supposedly a medical doctor. All he wanted to know was what's my condition right now and give me an assessment on that. He doesn't care what I feel when I leave. You know he takes a history of how I'm feeling when I come in but I'm wiped out from the tests when I leave. I voice that concern the following time I go back but he says, "You have to do these tests, plain and simple." He doesn't care how you feel about it. (Male patient about his specialist).

Although strategies such as these may be planned through the patient having prior expectations of the encounter and having anticipated the problematic aspects of interaction, they may also develop in the course of the interaction:

Well, I had a back problem and my doctor told me I should spend two weeks in bed. I told him I couldn't do it, my son was graduating that weekend...so I did that the next week. (Female patient about her G.P.)

This emphasizes the emergent and negotiable features of patient-physician interaction.

In discussing the negotiable aspects of face-to-face interaction, we must realize that "strategies" available to patients in terms of exerting power and social influence are not enacted in an open arena. For example,

patients are often somewhat limited in their possibilities for action in that they can perceive the knowledge and information available to them to be of a different order from that of the physician (lay knowledge vs. professional knowledge). As one male patient said:

It's important to listen to what your physician is saying and listen carefully. If you have any questions by all means ask, make sure everything is clear. And if you think the physician is right, well, you know, who are you to say that he isn't. You don't know as much as he does. So if you don't think a second opinion is necessary, then you should do exactly as he says.

A second limit is in the patient's perception of what is possible. Patients often perceive that they are constrained by the amount of time available for interaction, therefore, they don't always "get what they came for" in terms of having all their questions answered or problems attended to. One female patient was troubled:

When I'm there he usually gets me in fast but he gets me out real fast, you know. Five minutes and you're out the door. He's so rushed. I like to know exactly what's going on.

A third limit to strategic interaction concerns areas of 'implicit agreement in interaction. Stimson and Webb (1975:40) suggest that orders in the consultation are maintained by complicity, by agreements on the way certain aspects of the encounter are to be managed - such things as the use of jokes, the modes of address each use, the emotional flatness of the consultation, and the use of reassurance and empathy. Such aspects might, in lay terms,

be summed up as "a good rapport":

I've got a pretty good rapport with him. He like to joke around to put me at ease, or if he doesn't know exactly what to do. That's what comes across to me sometimes.

What is important to emphasize with regard to these limitations to negotiation is not that certain strategies and expectations concerning power and social influence are not all negotiable, but that they can be less negotiable than other aspects of the interaction under certain circumstances. To be sure, the negotiable aspects of the interaction vary with the "type" of patient and the "type" of doctor that come together to form a relationship. For example, Active and Demanding Patient types can insist that the doctor devote more time to their problems, whereas a Passive patient may perceive such demands as non-negotiable. Furthermore, a patient's expectations and perceptions about the negotiable aspects of the negotiation can be met with approval or disapproval depending on which doctor type a patient interacts with and under what circumstances. In short, patients are faced with the problem of "figuring out" their doctors.

During face-to-face interactions both doctor and patient are concerned with assessing each other, but the central focus of this study is patients' perceptions of doctor-patient interactions. It was found that patients do not always agree with a doctor's interpretation of their symptoms and what should be done, especially when this is

not in accordance with their own preconceived ideas and the doctor has not stated his interpretation in terms sufficiently convincing to persuade the patient to accept it. One woman, a Demanding Patient type, consulting a doctor about her twelve year old daughter whose condition the doctor had interpreted as being "an emotional problem" and "nothing too major to worry about", persistently reiterated that the symptoms in this child were both unusual and worrying:

She (daughter) was vomiting a lot and I asked him if maybe there was some internal blockage somewhere. But he kept saying her problem was emotional. We finally had to get tough with our doctor and insist that he look for this possibility. So he booked her for exploratory surgery and they did end up having to remove this growth.

Thus, certain patients can persuade their doctor to acknowledge their own perspective of the problem. However, other patients are not always able to achieve this kind of result as reflected in the following statement by a woman who consulted her doctor about her sore knee:

I felt, since I wasn't incapacitated, that he wasn't too concerned. I felt that he didn't take me too seriously. I suppose if I were in more pain or having a more severe problem, I may have been a little more enthused ..um..more vocal.

As I've mentioned earlier, in Chapter 5, patients sometimes report that they feel, or can be made to feel, that their problems and concerns are trivial. This can lead the patient to feel that they are guilty of "wasting the doctor's time." Although it can be assumed that a

patient's presence in a doctor's office is testimony that they perceive their problem to be above the status of a "trivial matter" and worthy of the doctor's time. Patients appreciate the doctor endorsing this. As one person stated, "When you talk to him, he doesn't make you feel like you're wasting his time." The doctor has a basis for evaluating the trivial and serious that is not available to the lay person. Bloor and Horobin (1974) speak of the "double bind" expectations of the patient, on the part of the physician:

...the sick person is expected to analyze his condition in terms - is it serious or non-serious, does it require medical treatment or some other alleviative action, etc. - which imply diagnostic and prognostic evaluation, but on presentation to the doctor, the sick person is expected to "forget" his own prior assessment of the condition and defer to the doctor's (Stimson and Webb, 1975:46).

A physician's motives for making statements such as "It's not that serious" or "You needn't worry" or even "Look, do as I say - after all I'm the doctor", may be to reassure the patient that there is no real cause for concern and that they can trust the physician's judgement. Yet, an unintended consequence can be that patients perceive themselves to be in a position where they feel the doctor is inferring that their perspective of the problem is nonsensical. Alternatively, it can be suggested that doctors may actually be trying to evoke this feeling in the patient as a means of enforcing that they are in control of the situation. It appears that in many cases

success with regard to persuading a doctor to be attentive and open to a patient's perceptions of a particular problem is largely dependent on the "type" of doctor he or she encounters.

INFLUENCING THE DOCTOR

In face-to-face interactions the control and influencing strategies the doctor uses can be more overt because in some respects he is expected, as a doctor, to instruct and direct; to "act" like a doctor (Stimson and Webb, 1975:50). This gives them certain strategic advantages when we consider the possible controlling and influencing techniques available to each participant. In one sense, doctors, especially specialists, can wield a great deal of power because ultimately they control access to treatment resources. This can have a serious impact on how patients voice their concerns and demands. One male patient who was suffering from migraines and occasional seizures indicated a concern about demanding more time from his specialist in discussing his problem for fear that he could alienate this doctor and jeopardize further treatment:

...it's like I say, if you challenge the guy then forget it, you don't get no answers. It's like you got to be dumb, and the way I look at it, hey, I'm not dumb. I'm not some goof off the street. I like to know what's going on. But yet, if you challenge him and tell him and tell him exactly how you feel, no, you gotta back off or you'll make him mad.

Thus, patients can feel powerless in circumstances where they think they must "back off" from voicing their concerns about the poor features of the interaction process in order to receive desired treatment resources.

It is possible to differentiate stages where doctor and patient are verbally active or passive. For example, during the description of symptoms, the patient is usually the more active of the two initially, but often the doctor interrupts with questions or additional comments or that he or she has heard enough and can proceed with the examination or diagnosis. This usually marks a transition from the patient to the doctor, being the active negotiator. At this point the doctor gives his explanations of the symptoms and makes recommendations. The patient may supply additional information or inquire about what the doctor has said but usually the doctor remains the more active of the two in the exchange by offering advice or issuing instructions. The response of those persons interviewed in this study indicated that either patient or doctor can exert power or social influence by dominating the verbal exchange (naturally some doctors and some patients are more verbal than others). However, in general it was felt that patients tend to be the more passive of the two. Patients, even those who presented themselves to be Active or Consumerist Patients types, did not readily give open expression to

feelings of disagreement or dissatisfaction to the doctor's face, justifying such inaction with responses like: "It's not my style to do so" or "It's not part of my personality" or even "It wouldn't do any good anyway." The question is then what strategies do patients employ in influencing and controlling face-to-face interaction?

Stimson and Webb (1975:53) have suggested that "repetition" is a device used by patients to control interaction. A patient rarely contradicts a doctor, but expresses dubiousness or doubts by rephrasing, reformulating, or repeating his or her statements. Recalling the woman who insisted that her twelve year old daughter's illness was not emotional, we see that by refusing to let the matter rest, she persuaded the doctor to agree to take action. This strategy is perhaps better illustrated by the example of a woman who had consulted her doctor about her two year old son who uncharacteristically began rocking and banging his head against his crib:

I finally put my foot down ~ like, "do something, recommend something", and he said, "Let's send him to Dr. R. (pediatrician).

I. Do you think he would have recommended this specialist if you hadn't put your foot down?

I don't know, maybe, eventually. I think I had to get upset. Like I said, E. (son) had been doing this for a year and the doctor wasn't taking it seriously.

"Repetition" as a controlling and influencing

strategy available to patients seems to be popular among Demanding Patient types but is less frequently used by Active Patients and almost never by Passive Patient types. It can be suggested that Passive Patients may be missing out on important opportunities to exert power and social influence in interaction with physicians by virtue of their quiet, non-aggressive nature. Without that little push of persistence from patients, doctors who could otherwise be persuaded to act on the patient's wishes may opt out for the path of least resistance - namely a traditional one-way influence form of communication where the doctor controls the interaction.

Another type of control strategy is what Stimson and Webb (1975:54) refer to as the "appeal to the normal", a reference to what is claimed as usual. Ideas about what is appropriate are based on previous experiences with the medical profession and of the problems being presented, or the experiences of others upon which comparisons can be based. As one young woman explained:

I felt like I had strep throat or some sort of problem which I have experienced in the past and I know requires penicillin to cure it.

Although patients can and do use the "appeal to the normal" as a strategy to influence and control the interaction so too, do physicians, and with greater rates of success. Responses recorded in this study point out

that doctors often appeal to what other doctors or colleagues have done. In many situations doctors will stress their previous experience with certain types of problems and the way in which other patients have benefited from the treatment he or she prescribes in order to lend conviction and authority to his or her statements.

The doctor can also appeal to the body of knowledge which he or she represents and which is not available to the patient (competence gap). It is an appeal to the "facts" of institutionalized medicine. Often a physician will tell the patient that there is no other treatment, a test or procedure is inappropriate, or that all that is possible has been, or is being done for the patient. Consider the following example about a young female patient suffering from a back injury sustained in an automobile accident:

There was . this time, there was a story in the paper about a girl who was in the same predicament I'm in, and they gave her some kind of shot. But I asked him and he said it wouldn't be worthwhile to get it. Well I've been told by a couple of doctors that I have to stop trying to go farther, I have to accept the way I am, but I don't want to. He said that it (injection) would be a waste of money. But that's easy for him to say because he doesn't feel the way I feel. Now I'm sure he cares but, you know, I still want to try.

The array of responses recorded during this study have led me to suggest that perhaps the most effective controlling and influencing strategy available to patients

lies in information seeking. Patients who gather information prior to face-to-face interaction with a physician and use this information to ask questions and make suggestions are much more successful in having their problems and concerns attended to in a manner they perceive as appropriate. Patients who seek information concerning their problems are, in effect, narrowing the "competence gap" between themselves and the physician, and, as evidence suggests, are in a better position to question and discuss a diagnosis and/or treatment recommendations. As one woman stated, the doctor who treated her five-year-old daughter's cleft palate seemed to respect the woman's knowledge of the condition:

I really feel that this (information gathering) established me in his eyes as someone who cared enough to find out and therefore he would relate to me as, you know, an intelligent, informed person and never once has he been patronizing.

I. Do you feel that this had certain advantages?

Oh definitely. I don't think C.'s care, I mean I have to trust that he would give C. the best care even if I was the most obnoxious woman, or the dumbest, or whatever...I thought he was very careful to inform me every step of the way.

I. Do you think that he may not have been so free in sharing information if you weren't so up on all the ins and outs of the situation?

Probably not, because a lot of the information he told me was because of the questions I asked, that I felt were good questions.

An important distinction can be made about patient and doctor types regarding the usefulness of information

seeking as a strategy for control and influence in the patient-physician relationship. Passive, and more specifically, Demanding Patient types are less likely to report satisfaction with Authoritarian Doctor types who "don't listen" to them or are seemingly "unsympathetic". The author suggests that the main reason for this may be that, characteristically, Passive and Demanding Patient types are low information gatherers and low information sharers. Thus, Authoritarian Doctor types tend to look down at them and will more readily dismiss their concerns and demands as "hysterical" or "illogical." On the other hand, Active Patient types who are high information gatherers and information sharers, stand a better chance in influencing Authoritarian Doctor types in having their concerns addressed.

It is reasonable to assume that patients are somewhat responsible for the form of interaction (one-way or two-way communication) that takes place in doctor-patient encounters. If patients, by virtue of their actions and responses during interaction with their physician, can dispel some of the common assumptions about the patient's role (i.e. inferior status, competence gap) they are, in fact, influencing their physician.

Thus the Active Patient who does not perceive a need to be a consumerist in order to find a doctor who meets their expectations may not have had to, because they have shaped

the behavior of their physician.

One can speculate that in some cases Active Patient may be responsible for creating their own referent/patient as equal relationships, regardless of the doctor type they initially interact with. (Possibly not a Doctor God type, but certainly with a borderline Authoritarian or Doctor Nice type). On the other hand, passive patients may be responsible for "setting themselves up" in traditional/one-way influence types of relationships by virtue of their low key patient role. Since traditional types of doctors rely heavily on expert power when interacting with patients and tend to typify the ideal patient as someone who has sufficient expertise to know what symptoms to present and when he or she should present them, Active Patients pose less of a problem for them to deal with than do Passive or Demanding Patient types and are thus more likely to receive better attention and care.

The experience of a twenty-six year old mother spotlights the difference between Active and Passive patient types and the importance of information seeking as a control and influencing strategy available to patients. This particular woman took her one-year old child to a specialist on the recommendation of her family doctor to deal with a breathing problem the child was experiencing:

First he said it was just croup, but she wasn't getting any better and she turned blue on him-there. Eight days went by and I thought something else had to be done. The nurses said to me, and this was in

the hospital, that she shouldn't still be there, she should have been cured and gone home. So I asked the doctor and he just jumped on me like I was silly. He said I was stupid and it was none of my business, and if I didn't like it, find somebody new. So I bawled my eyes out and thought, "What am I gonna do now, who can I turn to?", because you're supposed to go to them. He acted like I didn't know what I was talking about, which I didn't know, but she was still sick. I told my family doctor I didn't think he was doing his job, so he got this Dr. V. The next morning I went in there and there was Dr. V. who is an allergy specialist, and he said, "Take her off milk, now!", and in twenty-four hours she was fine, perfectly fine. Well, Dr. G. told me to find somebody new.

- I. When you decided to leave Dr. G. was it on your own or after the nurses told you your daughter should have been O.K. by this time?

Yeah, that's when. I didn't know she shouldn't have been there for croup for that long. I didn't know nothin' about it. It wasn't until the nurses said that that I started questioning him, like why isn't she getting better.

In this case the patient did not initially challenge the doctor despite her frustrations. It was not until the nurses, who via their professional role, were perceived by the patient to have sufficient expertise to challenge the physician and whose concerns could act as a catalyst for the patient, that she voiced her objections and sought help elsewhere.

This patient reported that this episode was a real learning experience and she recently has become more active insofar as seeking information on her own and using that information during face-to-face consultation. With regard to her new patient role and her relationship with the allergy specialist, the patient responded with an

interesting comment:

- I. How would you describe the ideal doctor-patient relationship?

Oh, Dr. V., the same relationship I have with him. I can go in there and talk to him and he'll answer anything. He makes you feel like you're a part of it, you're not the one who's left out.

- I. Have you ever felt left out or that you didn't have any say in some matter, in your experience with Dr. V.?

When we first started, yes. Like all the tests they were going to do on her, and I didn't know what all these tests were, and he didn't really explain them then. But he did later, cuz I came home and read about them and asked questions then. So at first he was...not that he left me out in the cold, it's just...well he's good.

CONSTRAINTS ON INTERACTION

What patients attempt to do during face-to-face interaction is often limited by what they perceive as possible. Certain factors are frequently mentioned by patients as either possible barriers to effective communication, or other problems related to "getting what they want." Constraints operating in the interaction process provide the limits to the interaction, serving to contain or control the strategies of the participants. In this context, it is appropriate to speak of the limitations imposed by the perceived confidence gap between the patient and the physician, by a perceived social distance between the two, and the significance of time.

Upon reaching the decision to visit a physician one can argue that the patient is recognizing the doctor's claimed expertise by virtue of consulting him or her. There is, in effect, a perceived competence gap indicative of the different types of knowledge available to the two participants (lay knowledge vs. professional knowledge). Because the doctor is seen as having access to specialized knowledge that is not available to the patient, this gives the doctor the ability to act as the primary decision maker in the interaction process and allows him or her the greater control. While patients can and do make decisions about their health both prior to and after the face-to-face interaction, during the period when they are with the doctor, they are asking for that specialized knowledge to be the basis for explanations and decisions made on their behalf.

The doctor can use his claim to special knowledge to control the patient; perhaps by threatening to refuse to treat the patient if the patient does not follow his instructions. It is almost as if the doctor were saying that if the patient does not believe in his competence - "have faith in him" in popular terminology - then he, the doctor, is unable to work under such conditions. Similarly, the doctor is always able to dispute the patient's use of a medical term, or claims to medical knowledge or doubts about the doctor's diagnosis or treatment. The doctor can always remind the patient that "I'm the doctor" (Stimson and Webb, 1975:58).

The perception of a competence gap does indeed hinder the controlling and influencing strategies and the development of a patient as equal relationship. However,

patients, specifically Active Patient types, are combatting the competence gap and have, in some instances, succeeded in containing a physician's dominance by information seeking in the "micropolitics" of the medical encounter. Patients are becoming more informed and are, therefore, more specific when speaking to physicians about their problems and what can be done for them. Many of the subjects interviewed for this study indicated that they have sought information on their own to help them become "more involved" during face-to-face encounters. One patient reported seeking information from a local health information service, however, most "information seekers" use the resources of their local libraries or obtain pamphlets or medical journals to consult before and after interactions with the doctors.

Increasingly, popular magazines have been devoting a good deal of space to advising potential patients on how they can pin down problems involved with talking to their doctors. Most "women's" magazines have traditionally featured regular columns on health care. Recently entire articles have been devoted to medical communication. Family Circle, for example, offered readers "How to Understand Your Doctor" through an alphabetized "Guide to Medical Language" (Nierenberg and Janovich, 1979). Good Housekeeping offers a 928 page "Family Health and Medical Guide" comprising information and advice from thirty-seven

contributors (Liles, ed., 1980). Cosmopolitan featured "Are You a Smart Patient?" (Belsky, 1978), stressing important questions patients often forget to ask. Such examples indicate the extent to which the doctor-patient competence gap is generally acknowledged.

The reasons patients gave for information seeking generally reflected a desire to become more active and more in control of the encounter. As one male patient indicated:

It (gathered information) really made me identify with my problem and to ask the proper questions ...I'm not intimidated, like I feel I really know something and can share it with them (doctors).

Some patients have been successful using information seeking as a means of increasing their knowledge and narrowing the competence gap between themselves and the physician. However, all those who employ such a strategy are not being met with positive reactions from their doctors. As mentioned earlier, patients who use informational power to challenge their doctors, can often be met with negative responses ranging from a gentle dismissal of the patients viewpoint, to open hostility, especially with traditional types of doctors. One of the problems with information seeking as it applies to establishing a "good" relationship with a physician, is that the competence gap is over-assumed by many physicians. It appears that doctors often typify patients as persons who cannot understand the "mysteries" of modern

medicine, even when a patient displays a reasonably sound knowledge of a particular condition or problem:

I remember three years ago I was in F.'s office (G.P.) and he said, "I bet you don't remember what J. (patient's son) had that operation for." I said Pyloric Stenosis, and I explained the operation to him. He said, Well, I didn't think you'd know all that!" I said, "Well I looked it up, he's my son." That ticked me off.

I. Do you think he responded that way because you were a woman?

No. No. I think they view all patients as pretty dim-witted. You know, like they're "out to save 'em" (laughs). "You don't have to know what I'm doing."

This comment raises an interesting point about the perception of a physician's inappropriate behavior as a feminist concern. Of the ten women interviewed, only one perceived the "shabby" treatment she received from a physician (a Doctor God type) to be reflective of a poor attitude towards women;

He said, "These woman who come in here and think because they have a child they know all about medicine." I realized at this time that he had no respect for the fact that a Mom would indeed know her own child...He made it clear to me that a Mom's opinion wasn't too valuable, and I was distressed at that because my own personal opinion is that that's exactly where you get the information.

I. What if you had been a male? Do you think this would have made any difference in the way he would treat you?

Oh, without a doubt! If I had been her Dad, or even her grandfather, there's no doubt in my mind that I'd have been listened to. I was intimidated by the fact that I was female, I did allow myself to be a little bit intimidated. I thought he could see I was an educated person and not hysterical.

Other women who reported poor experiences with

physicians did not express a belief that the problems they encountered during face-to-face interaction with a particular doctor would be any different for a male patient with a similar problem. In fact, one woman related an experience that was in direct contrast to the situation outlined above:

One time in the hospital this doctor (family doctor) said, "Oh yeah, we listen to Moms because we have to, they know what they're talking about." And that made me feel good you know. I'm not being hysterical or stupid. I know what I'm talking about, and at least this guy patted me on the back for it.

Dr. John Fisher (1977:169) speaks of another more serious problem associated with information seekers:

A little learning is not only a dangerous thing. When exhibited by patients, it can also be downright annoying. And more and more patients are exhibiting it. With the growing number of pseudoscientific articles in the lay press, the physician's word is increasing being questioned.

Fisher seems to imply that the very legitimacy of the physician's occupational status may be imperiled by the patient's increased activity and inquisitiveness.

Although many traditional doctor types may share Fisher's concern for the consequences of increased patient assertiveness, there are also those doctors using referent power who encourage a high degree of patient involvement and may even shudder at the thought of shouldering total responsibility for the patient's health. Especially in these times where many people appear to be "litigation crazy" and the costs of playing God can be

high, antielitist doctor types are prone to welcome patient assertiveness in a patient as equal approach which spreads the obligation of responsible health-related communication over their relationships with patients. As West (1984:3) notes, serious long-term difficulties can arise from a "failure to communicate", including ambiguities whose resolution is likely to take place in the courtroom.

Social researchers have suggested that the competence gap is matched by a social gap. Stimson and Webb (1975:58) maintain that class and cultural differences, as well as those emanating from differing perceptions and orientations of the professional and the layman may make for a certain degree of social distance between the two. There may be a number of other reasons, both structural and psychological, that one could consider but the contention here is that many physicians opt for an authoritarian model of communication with their patients because they are unable or unwilling to identify with patients who occupy a lower social class position.

Furthermore, as reported in the review of the literature, it has been suggested that patients of a working class and middle class background, will, at present, agree with a traditional/one-way influence style of interaction and take it as normal and expected behavior towards them. Although this study was not intended to be

representative of the general population, I found no support for such a claim. It is this author's feeling that it is more appropriate to suggest that acceptance of the traditional patient-as-inferior model is more typically a Passive Patient trait rather than the characteristic behavior of a particular social class. There was not a cluster of working class or middle class patients among those who reported expectations of a traditional style of interaction, or those who reported "good experiences" with Authoritarian doctors.

Time is another factor which acts as a constraint on face-to-face interaction. As alluded to earlier, patients perceive and report that doctors frequently express their irritation at the "trivial complaints" that "take up" their time. Patients also recognize that the doctor is a "busy person" who should not be troubled with trivial things. The doctor's time is seen as a valuable commodity by him or herself, his or her staff, and by the patient. However, it is only the Passive Patients types who see a physician's time as more valuable than their own:

He kinda explains what he's doing really quickly. Sort of like "I'm going to be doing this and doing that; you'll have to wear a colostomy bag for a little while", and um... But he did it so fast that I just said, "O.K.", cuz he's always busy too, so I didn't want to take up too much of his time. I figure he knows what he's doing, right. (Male patient about his specialist).

An interesting power dynamic surrounds the concept of time as it concerns the patient-physician relationship.

of time as it concerns the patient-physician relationship. Interview subjects made reference to a perception that they can be made to feel they are wasting the doctor's time, but the doctor was rarely accused of wasting the patient's time. Of the seventeen interview conducted, only one patient actually complained of the doctor wasting his time. In terms of this study, almost all the complaints concerning time reflected patients' dismay over the fact that their physicians were "rushed" and could not spend the desired time with them to fully attend to their problems and questions. This was seen to be the most frequent problem reported among all patients types, specifically in regard to encounters with general practitioners. Two female patients had this to say about their G.P.s:

I expect him to treat me like a person not a number, and be willing to spend as much time with me and, you know, if I have any questions he'll answer them. I think he's a good doctor and he's a nice person but, I feel like I'm on an assembly line and he's a dispatching agent, he's a clearing house.

And:

I get in there and he's always in a rush. He gets you in fast and he gets you out fast. He's always in and out of the room, you know. He answers your questions but he's quick about it, so sometimes you walk out of there and you go, "Gosh, I forgot to ask him this."

Thus, for most patient types, having an appropriate reason to consult a physician justifies their demands for a doctor's time.

It is quite evident that doctors have the power to control the length of an interaction and the nature of the encounter. Simply by appearing rushed or by giving quick or ~~flippant~~ responses to patients' questions, face-to-face interaction can become, for many patients, little more than a trip through a revolving-door. However, patients are not totally powerless in regard to how time is managed during doctor-patients encounter, especially Active and Demanding Patient types. Patients can employ strategies and techniques to terminate and prolong an interaction. Terminating an interaction depends largely on discouraging the doctor from continuing by reducing feedback to him or her. This strategy was illustrated by a woman who refused to be drawn into conversation and stated that she just wanted her prescription so she could go home.

To prolong a conversation, patients can do the opposite of this. They can ask further questions, or ask earlier ones in a new way, or by bringing a list of questions and refusing to leave the doctor's office until he or she has addressed all of the concerns.

REASSURANCE, SYMPATHY AND EMPATHY

Reassurance, sympathy and empathy are common expressive features of doctor-patient interaction. It should be noted that doctors frequently imply that patients' problems are "not that serious" or "nothing to

worry about." Phrases used by the doctor, such as: "Yes, I understand" or "I know it can be rough" serve to express an appreciation of the problems the patient is experiencing. However they also serve to reinforce the physician's authority, competence and control of the interaction process. A male patient who reported that he did not fully understand the details of an upcoming operation and that information transfer from the doctor was minimal - "He sort of told me in a broad sense" - also gave the impression he was not too concerned about the lack of detailed information. He expressed that his physician was quite sympathetic and caring:

I felt that someone was there just for me...I felt a little more secure in myself because I knew someone was there to help me, cuz it was scary.

This patient perceived a sense of concern which helped to reduce anxiety as well as instill a sense of faith in the doctor. To the Passive Patient type, the perception of a genuine sense of concern and the doctor's willingness to promote and insure this feeling, for the patient, becomes more important than information transfer:

The way he used to talk to me, the way he set me up, I never really thought of this as a major operation...I remember about a day or two before the operation he comes up to me and says, "Are you ready for this?" I said, "Yeah, don't worry, don't worry." And actually I never did worry, with him anyway. I trusted the guy a lot and ah, maybe if it was some other doctor, maybe it would have been a little more tense or something like that.

This example shows that a display of sympathy and a

patient's perception of a sense of concern can play an important role in allowing physicians to exert social influence on their patients. Once a physician has conveyed a "genuine" sense of concern for his or her patient, securing a patient's trust in the physician's judgement or competence becomes a relatively easy task. Once trust has been established, a physician's ability to exert expert and legitimate power insofar as making patients comply to a recommendation or adhere to a medical regimen, becomes easy. Furthermore, once a physician has a patient's "complete trust" that physician doesn't have to share power in terms of a high degree of information transfer and mutual decision-making. This can be especially significant when physicians are dealing with Passive and Demanding Patient types who could lean towards taking a consumerist perspective. This is not to say that physicians use sympathy as a conscious strategy to avoid sharing power with their patients. But then again, It is not unreasonable to suggest that some physicians use reassurance and/or sympathy in promoting a sense of concern as a method of avoiding challenges from patients or to avoid spending "valuable time" discussing options and procedures in what can be lengthy information transfer interactions with patients.

Other researchers have alluded to the use of sympathy as a strategy to promote and maintain a aura of

recorded the comments of a student-physician who summarized the relationship between acting competently and patients' responses to such performance:

You know the patients put pressure on you to act as if you're in the know. If you know anything about the placebo effect, you know that a lot of the healing and curing of patients does not involve doing anything that will really help them, but rather creating confidence in the patient that things are being done and will be done. We know that the placebo effect, for example, has even cured cancer patients. If they have the confidence in the doctor and what treatment they are undergoing, they are much more likely to get well, irrespective of the objective effects of the treatment.

Haas and Shaffir (1977:84) feel that student physicians learn the practical importance of what they call the "cloak of competence", strategies that they adopt as part of their professional role. It provides patients a "taken for granted" situation about the competence of the physician that is important for their confidence in the physician and the treatment process. Thus, for many physicians, that use of reassurance and sympathy can instill in their patients a trust in their competence and may help the physician deal with, or avoid dealing with, the unpredictable and potentially threatening reactions of those who evaluate their work.

Many patients comply with the orders of physicians who use reassurance and sympathy, and report that a perception of the doctor's concern helps reduce anxiety about treatment recommendations. However, other patients, specifically Active and some Demanding Patient types,

specifically Active and some Demanding Patient types, report that these traits are not enough for them to feel truly confident in the doctor's ability and satisfied with the relationship. Evidently, many patients feel that doctors are sympathetic but not empathetic. That is, many doctors appear to care about the patient but are perceived to be too caught up in their professional role to truly identify with a patient's problems and understand the reality of an illness from the patient's point of view:

He cares, but I was frustrated with him. He makes you think like you're overreacting. You shouldn't do that to a person. He wasn't taking it seriously. (Woman about her G.P.).

A male patient relates a similar experience with his specialist:

Like the six months I had to wear that colostomy bag, I never dated a girl or nothin'. I could've, but I just didn't feel right. I was too embarrassed and all that, eh.

- I. Do you think he took into consideration your lifestyle, your age, and the things you wanted to do?

I always wondered that. I told him the things I was doing, like going to school, and I'm working also. I was living with my girlfriend at the time, and he knew that but I don't think he knew what my lifestyle was really like. How I liked to go out at night and have a few drinks or stay out late at night, you know...I asked him why he put my colostomy bag so high, because normally they're really low. And he says, "Because that's just the place I normally like to put them." You know, after awhile, when I got used to it sort of, I think that's actually a bad place to put because you don't really have too much motion or flexibility with it because it's right there.

As the above case illustrates, a physician who uses

expert power but does not incorporate referent power as part of his or her professional role, does not identify with the patient and therefore, can fail to inquire about the meaning to the patient of pain, embarrassment, or other problems associated with the wearing of a medical device. In general, physicians who do not readily use referent power in face-to-face interactions with their patients are often perceived to exclude from consideration important aspects of the patient's life situation.

CHAPTER SEVEN

AFTER THE INTERACTION

The analysis of the interaction process continues beyond the face-to-face contact between patient and physician. People evaluate both the interaction during the consultation and the recommendations made by the doctor. There are specific bases for making these evaluations including comparison with the patient's prior expectations (usually based upon the patient's prior experiences with doctors, illness, and medicine), a comparison of the experience of others, and the circumstances under which a patient has consulted a physician.

Stimson and Webb (1975:76) suggest that in reappraising the consultation patients come to assess their doctor's actions:

Did the doctor act as anticipated, was his behavior appropriate in terms of how doctors usually behave, and was his behavior consistent with how he as an individual usually acts? Included in this appraisal might be a consideration of whether the doctor devoted enough time to the consultation, showed concern, appeared competent, or carried out expected examinations and tests.

EVALUATION OF THE ENCOUNTER

Most patients evaluate the outcome of face-to-face interactions in terms of what was expected prior to seeing the doctor. In Chapter Five, it was suggested that many of those interviewed had a clear idea of the outcome of the encounter. Expectations can be thwarted in many ways.

"the pill pusher" - or they may not prescribe or recommend a particular treatment that is desired. Some patients stated that they entered into a interaction with a physician expecting a particular drug, either one they had received before or one they had heard or read about, only — to have the doctor disregard their request or prescribe a different drug. One man described his frustration at not receiving a drug he expected:

Like I'm always hearing about different things and I'm saying, "Well jeez, these guys are benefiting from all these things, why not me?" He always kept me on the same pills all the time, and I guess at times I kinda wondered what the hell he was doing.

- I. Did he explain what would happen if you took these new pills?

No, no. He'd explain what it was for...but he'd say, "I don't think that's right for you."

- I. Did you ask him why it wasn't right for you?

Yeah, I guess I did. I really don't remember what he said.

- I. Did you ever leave his office feeling like you didn't really understand why you couldn't take a drug that you heard was benefiting some other guy?

Yeah, I did leave like that. Because you see this guy and he's all right, and here I am in pain. He told me this drug's cuz this guy's got diarrhea. But yeah, I have that too, you know. But he said, "That's not for you", and he really didn't say why I couldn't take it. I think it was because he didn't like that kind of therapy. But I kinda went outta there feelin', "Well jeez, maybe it would've been better to try it out or something. But then sure enough I turn around and say, "He knows what he's doing".

It is important to note that even the Passive

It is important to note that even the Passive Patient who is the most likely of all interactional types to comply with a physician's recommendations and sometimes expects an asymmetrical power relationship, can still report feelings of frustration and anxiety when their attempts to become more active are stonewalled and/or questions regarding that patient's health are not adequately answered. As mentioned, Passive Patients can become aggressive and non-compliant if they feel the situation is serious enough to take such action. However, such reactions tend to be emotional responses such as "reactance" rather than the thought-out reactions of an informed consumer.

For patients, who did not have clearly defined expectations about the face-to-face encounter, they find that the period after the interaction is a time for appraisal and they begin to speculate about what they really wanted out of the relationship. Although some patients were not able to say prior to the interaction what it was he or she expected from the doctor in terms of his or her behavior and recommendations, going over the encounter brings to light that perhaps the patient would have liked the doctor to have done more. This researcher found that such appraisals tend to focus on what patients perceive to be a lack of information sharing. As one male patient reports:

In the back of my mind I thought, you know, how I have to ask questions. But I always thought when things got a little more serious with the medical terminology, I didn't know anything about that, I thought that he'd volunteer his diagnosis and say what the hell's going on and all that. But he's not like that.

Final evaluation of face-to-face interaction is also made up of what the patient and the doctor actually accomplish in the encounter. Patients assess themselves to some extent by asking themselves if they asked the "right" questions and whether or not they got across their point of view to the physician. In other words, patients will look at how they managed the patient role in terms of their prior expectations and/or preparations. Thus, patients can criticize and blame themselves for poor outcomes, especially Passive Patient types who seldom make demands on their doctors:

If I have any questions I usually don't say anything. And afterwards I'll think about it and go, "I should have asked that."

Some patients blame themselves and their doctors for problems associated with the face-to-face encounter. While criticizing their doctors for being "too busy" or "too rushed" certain patients will still shoulder some of the responsibility for unmet expectations:

I can tell when I walk in there when he has time and when he doesn't. When he's rushed I'm rushed.

I. So you go in and judge the situation and sort of adjust yourself, rather...

...than making him adjust to me, right, exactly.

I. Do you feel that's the way it should be?

Um...No, because I feel I'm his patient and he should take the time out. But here I'm doing it, I'm doing it, adjusting to him.

Furthermore, the circumstance under which a patient and a physician come together has a strong impact on how patients evaluate problems within a particular interaction. One woman who felt that her doctor is always busy, reports that this doctor will heed her demands for time and information sharing:

It depends I guess. If I'm just going in for a check-up or if the kids have got a runny nose, I'm not going to take up his time. I mean, he doesn't need that. But if it's serious enough he knows I'm not an overreactive person or some kind of nut. I make him take the time.

One of the more interesting findings with regard to evaluations of doctor-patient encounters was the frequency with which patients make excuses and allowances for their physicians, specifically among Passive Patient types. The following conversation I had with a man who was fitted with a temporary colostomy-bag while recovering from Crohn's disease (a gastro-intestinal disorder), illustrates how some patients overlook or forgive certain aspects of the relationship with the physician:

I. Did he explain all the risks and some of the things you couldn't do, and how long it would take to recover from this operation?

No, he didn't explain all that, that's one thing he never ever said. I never knew what I should do or what I can do, so this is what we have. One day I went skiing with a friend and I had been drinking

just a little bit. But as soon as I have a little bit of alcohol, and that, part of the stoma, the intestine that sticks out of from the colostomy bag, it enlarges. So when I woke up the next morning I had a handful of my intestine sticking out. So I phoned him up and I went to Emergency, and there was blood everywhere, eh. And he's trying to push it back in because he did that before, but it wasn't going in. So they were shootin' Demerol into my legs, like a hundred twenty milligrams, eh, and it was so much pain, but it wasn't working. And he says' "We're going to have to put you under and fix you up."

- I. And it was the alcohol that caused all this?

Alcohol plus the activity.

- I. And he didn't tell you to avoid this?

No, no, he never said that. And he still never does talk a lot. So he had to put me under and fix it all up. And that's when he came up and gave me the three "No's". Finally. He says, "No drinking, no skiing, and no nothing like that."

- I. Were you upset at him for not explaining this beforehand?

I was never, ever ticked off. I was never mad at him, ever, never. I got to know him in a way that if I want to know something I have to ask him, which is not good either because sometimes, you know... Luckily for me I studied a little. I looked in a medical book about what colitis is, so I sort of knew about what to ask... But for some person who might not know what to ask the doctor knows everything, he knows what's going on. But I wish he'd come out and explain things more.

- I. Did this affect your relationship with him as far as thinking he should have explained this?

No, never, not once, not once... It was like we had a business - we were partners in a business - and we were there for one thing, and that was to cure me. That's what it was more like. I never once resented the guy for anything. He was good.

When asked what it was about this particular doctor that was so good or so positive that would allow him to

forgive the doctor for this lack of information sharing, the patient stated:

Well I don't feel any pain anymore, he fixed me up. And we are good friends, I mean friends always make mistakes, and, you know, you're supposed to forgive and forget and stuff like that. There wasn't any point in time where I said, "Hey, this guy's flipped out, I don't trust him" or nothin' like that. It was never ever like that.

This response raises an interesting question regarding the benefits of establishing a "friendly" relationship with a physician. A woman who spoke of her family doctor (a Doctor Nice type) reports:

As busy as he is, he's always got a smile on his face...He makes it like a social visit, he does. We're on a first name basis, it's just the way it's been, he's always made me comfortable that way.

I. Do you feel this familiarity benefits you?

No. At first I enjoyed it because you'd sit down, yak, have a coffee. But now it's hard to get mad at him, hard to challenge him. It's hard to sit down and say, "F., I'm tired of this running around. Do something, recommend something. So it's not always good to have him on that level.

Thus, it can be noted that "identifying" with one's physician can be a drawback of the antielitist model of doctor-patient communication, specifically with Doctor Nice types. Situations where patients put themselves in precarious positions by virtue of being over-accepting of their physicians was not reported as a problem with Referent Doctor types. This is not to suggest that Referent Doctors do not make occasional errors in judgement, however, since they characteristically share

and volunteer information and encourage a high degree of information transfer, one can speculate that patients that interact with them will not be "led down the garden path".

In cases such as the two above, it is difficult to say whether a patient's perception of equality in the doctor-patient relationship and what Elliott Krause defines as the patient as equal model, are indeed two sides of the same coin. The patient in the first case does report that he was satisfied with the performance of his physician; he trusted the physician's judgement and overall competence, and felt a sense of equality because the physician socialized, sympathized, and had a "non-snobbish" attitude. Thus we are left with an interesting sociological dilemma: is it appropriate to say there is equality in a doctor-patient relationship if the patient reports this to be the case, or does one only assign the equality label when the criteria of information transfer (through the volunteering of information by the physician), discussion of the options, and mutual decision-making have been met? In other words, does one reserve the "good doctor" label for those doctors who are the referent type and subsequently, the only "type" of doctor who truly operates within the patient as equal model, or should researchers such as Krause and others who endorse this perspective widen their scope for acceptance as "good" those doctors who, regardless of method of

operation, are deemed "great /doctors" by their patients? Indeed this question requires further interdisciplinary research.

Overall, the recorded responses of patients in reappraising their experiences indicate that particular skills are needed by both doctor and patient in order to avoid conflict within the relationship. In assessment and appraisal it was found that criticisms of the physician may be made but excuses and allowances are also made, and that many patients will have criticisms as well as praise for a particular doctor. It is important to keep in mind that the comments and criticisms that patients report in evaluating face-to-face interaction are a result of the natures of the physician and the patient, the type of behavior being influenced, and the situational variables present in the relationship.

CHAPTER EIGHT

CASE STUDIES

The following two case studies are presented here in order to give the reader a better appreciation of power and social influence as it applies to the patient-physician relationship. The first case study involves a twenty-two year old female teacher, who I define as a Passive Patient. She describes her experiences with a number of physicians, which should provide the reader with a better appreciation of the doctor "types" discussed in Chapter Four.

CASE STUDY #1

I. Can you describe your relationship with your physician? (Gynecologist)

R. He's very honest. He tells you everything right out. He tells you the pros and cons and everything, um, it's just that he's very, very busy. Like, you're an average of two hours in his office at least, if not three. He's always out delivering a baby or something, so a lot of times you feel a bit rushed because he's so behind. But if it's something serious enough, he'll stop and take his time, and um, it's not just medical, he asks what I'm doing now. And last summer, like, I thought I had an ulcer, and I told him I had an ulcer and he said, "Ohhh". He said, "You can always come and talk to me. I'm not just a doctor, I'm a friend." I thought "Oh wow," I really didn't expect that from him.

I. Did you feel like he was a friend?

R. Well, he makes an effort to keep up with you, so like he knows what I'm doing now. I'd never go to him to confide anything, I don't think it has to do with him, I just never imagined myself going to a doctor and telling him all my personal problems.

I. You mentioned you feel rushed sometimes, did you express that this bothers you?

R. No, no, I'm the quiet patient who won't say anything (laughs)...I guess he's, um, a domineering type of person.

I. When you feel rushed, do you feel that sometimes all your questions aren't being answered?

R. Yeah yeah. Even though he may say, "Is there any more questions?" you know there's twenty more people waiting out there, you feel like "That's OK, don't worry about it."

I. So you sort of adjust your behavior for him, rather than making him take the time to answer all your question?

R. Yeah yeah.

I. Do you think this is OK because he's rushed?

R. No no, I know if I was really depressed about something, he'd want me to ask him about it. But I guess it's because his office is always so full, and there's all there's all these big pregnant women in there, and I'm going, "Bye, it's OK, see you later" (laughs).

I. So do you feel your problems aren't serious enough to take up his time?

R. Yeah, exactly.

I. Has this ever caused a problem for you?

R. No, no, not with this particular doctor.

I. Have you ever had a bad experience with a physician?

R. Yeah. I was recommended to a gland specialist for my thyroid gland, and this is one of my worst experiences. I go to this office and the guy sits me down and says, "So why are you here?" I said, "I guess you're supposed to tell me." He looks at me strangely. He goes, "Are you having headaches?" I'm going, "No I feel perfectly fine." "Then, why are you here?" "Because my family doctor said something was wrong with my thyroid gland, and to see you." He said, "I don't see anything wrong with your thyroid gland," as if I should know what's wrong. I'm going, "I just went through a series of tests, you're supposed to tell me what they found. They called and told me to come and see you, and he's still going, "Well I don't understand why he sent you to me," it's as if I'm bothering him. I said, "Hey, I just follow doctor's orders, I'm here." You know, I'm not supposed to know, he's supposed to know...so he sent me for some more tests.

I. What were your expectations when you went to see this specialist?

R. Well, I thought he'd tell me what was wrong with my thyroid gland and he's going, phff, like it's ahh...

I. It's up to you to know?

R. Yeah, cuz my family doctor called me at home and said, "We have a slight problem," and you think, "I'm going to die." You know, when your doctor calls you at home you think to yourself, "OK, something's wrong," and you go to this guy who acts like he doesn't know anything about you, he doesn't know why you're there, as if you're wasting his time. Like even if I was there for some general questions I don't think he would answer them.

I. How did you generally feel about this?

R. He really made me feel like I was wasting his time.

I. Describe your relationship with your family doctor.
(Female GP)

R. She's awfully nice, she's very nice. Last time I saw her was for a T.B. test, and after that for my ulcer. She gave me this whole big spiel about, you know you shouldn't worry, so she took time out. But she's also very rushed. Maybe it's just her nature but she's always like, uh huh, uh huh, and she's always going, "OK, I'll be right back," and boom, she's gone.

I. Does she have a lot of patients waiting?

R. No, no, it's all very quick, it's just the way she is.

I. Do you feel you can't ask questions because she's so rushed?

R. Sometimes I think she doesn't give me the time to think about it. It's like (snapping her fingers) she's just a very quick person, and if you haven't thought about it in the two seconds she's given you, then it's too late.

I. Have you ever stopped her to tell her to slow down?

R. No. (laughs, a bit embarrassed) Nope.

I. Have you ever felt you wanted to?

R. Nope. I feel too intimidated by them, like, "OK, you

know the answers, I don't."

I. What are some of the things you typically do as a patient during examinations and consultations?

R. I listen, I go "Uh, huh, uh huh." If I have any questions I usually don't say anything (laughs).

I. When you do ask questions how do the doctors usually respond?

R. Oh, very positively. Like if I said I heard about this medication she (family doctor) recommended for me I'll say like "Will it affect that?" and he, I'm speaking about me gynecologist, he'll say, "there's these pros and these cons but it's up to you if you don't feel comfortable then don't." Because when I was in Grade 12 they recommended to me to take the Pill for my bad hormones and I said, "But I don't need it so why do I got to?" and it was like "these are the advantages and these are the disadvantages, if you really don't want to you don't have to" so it was left up to me.. He was really pushing for it and I said "No" and he said "Fine" and, you know, he said "Just keep up with the tests, and if we see that there's any serious problem we'll talk about it again".

I. Was having control over the final decision very important to you?

R. Yeah yeah, because when I first went, my family doctor recommended it (taking the Pill) and she made me, it wasn't a decision. She made me take it for awhile and I said, "I don't want to," and this is when I went to him and said, "I don't want to and don't see why I have to put this medicine into my body every day. I don't need it."

I. So how would you rate your gynecologist compared with your family doctor in terms of this experience?

R. Well I feel if I had gone back to her again and said, "Look, I really don't want to take the Pill," she probably would have talked about it again, but she was really strong for it and just thought I was being anxious over nothing.

I. What are some of the other things your doctors do during examinations and consultations?

R. Well she takes an interest into what I'm doing now, like last time I went to her I'd just gotten back from a trip and she said, "Oh that's very good." So she's very supportive that way. Like with my ulcers she's very

supportive saying "Don't worry." So she takes an interest in my mental health as well as my physical health.

I. Do you feel it's important that she gets to know what you're doing socially?

R. Yeah, so this way she sort of knows where you are in your life. One thing about her though is the way she's so quick and when she told me, "Oh, A. you have an ulcer," like it was up to me to ask what foods shouldn't I eat and stuff, and she didn't seem too concerned. I was kinda surprised, like you know, when you got an ulcer there's certain foods you're not to have and she never really followed up on that.

I. What do you like or dislike about your gynecologist?

R. Well even though his waiting room seems to have twenty more people in it, he seems to spend more time with me, over her (family doctor). It's like she's "Uh huh uh huh," she's picking out the important points and eliminating what's extraneous. He gives me material to read which is good. Or he'll tell me, "We just came back from this conference and we talked about this, this and this. Isn't that interesting?" He gets involved in these things and that's good. Also if he's about to examine me, he says what he's going to do, whereas she doesn't, a lot of times she doesn't.

I. Do you ever ask your family doctor, "I don't know what you're doing, can you explain this?"

R. No, nope. I figure she knows what she's doing.

I. Does she use a lot of technical terms?

R. No, cuz she doesn't say much at all. I trust her, I figure what she's doing is for my benefit, that if it was important enough to explain to me, she would. But I guess it's just something normal and routine to her so it's no big deal.

I. If you could have the ideal doctor-patient relationship, how would you describe it?

R. One who does take their time. One who is honest. One who right from the moment you sit down 'till the time you leave tells you all the information about what's happening, I like to know the little details.

I. So after an examination you want to know exactly what they found out?

R. Yeah, and without me having to ask. I think that they should be able to give you that information because they know what they're doing but we don't know exactly what they're doing. It's more their responsibility to divulge information instead of me always having to ask the questions. I think they should be more willing, more liberal in giving out information.

I. Does the volunteering of information make you feel less anxious, less intimidated?

R. Yeah.

I. Is there anything else you'd like to add about the ideal doctor-patient relationship?

R. O.K., spending time with me is important, open communication, um, availability at any time, and follow-ups. A lot of times you go for tests and unless they're negative they don't call you back. So even if there's even a little bit of a change, I like to know what's happening, that's about all.

-- The second case study depicts the experience of a thirty-five year old male who is suffering from hard metals disease (HMD), a cobalt-induced lung disease with has decreased his lung capacity. In contrast to the subject in the first case study, this respondent presents himself to be an Active patient. He has had a number of dealings with various physicians and his responses provide us with a personal perspective of how the Active Patient may handle the interaction game.

CASE STUDY #2

I. Can you describe your experiences with the physicians you've come in contact with concerning your illness?

R. O.K. The first doctor, he was a younger sort of doctor, new to the city, he really seemed helpful. He wanted to

do things step by step and take it slow and document things which I was completely satisfied with because at this point I felt that on my own, I knew it (illness) was a work-related thing, ~~but~~ it still hadn't been proven... But later I was dissatisfied with him because he didn't want to send any Compensation papers. He didn't want to get involved. He made the diagnosis, nothing in writing, just verbally, and he did tell me it was Hard Metals Disease (HMD).

I. Why do you think he backed off?

R. I think he just didn't want to get involved in it. It's a time-consuming thing.

I. Do you feel that one of the factors that made him shy away from this is that HMD is hard to diagnose and maybe he didn't want to go out on a limb?

R. It's true, yeah, I would say that that has some relevance. Well that's funny because to me personally there was no question, taking my work history into account and everything, it was HMD, no doubt about it.

Note: For the next six weeks this respirologist has him on medication but the patient continues to deteriorate. At work he is assigned a desk job.

R. During the six week period of working in the office, I continued to deteriorate and that's when I went on my own and contacted the specialist in London... He took a chest x-ray and some pulmonary function tests and he read the x-ray in front of us (wife was present) and he said he could see scars caused from, he thinks, caused from the cobalt dust powder. He actually wrote a book on the subject and he's very familiar with it. So at that point he booked me a room and kept me there (hospital) for eight days where I underwent a series of tests... all kinds of tests, and it was well documented and his final decision was it was definitely HMD. What really sticks out in my mind is the way he documented things in case he got challenged, to make sure, you know.

I. Do you feel he did this documentation to protest himself in case of any challenges?

R. Actually I think he had two interests, one, yes, to protect himself against if he's ever challenged, and two, to look out for my best interests. I really feel that way, that he was mainly doing it for me because there was a problem there and he really wanted to get at it.

Note: The patient was put on medication in hopes that it

would slow down and stop the scarring of his lungs.

I. Did the doctor explain all the ins and outs of taking this medication?

R. Yes, everything I had was explained. This was good about it. He actually gave me a paper on it (HMD) to thoroughly read before I had any testing done, to know exactly what he was going to do and what the reasonings were for. He talked to me about it and discussed it and then he said, "It is your decision." It's not something like, "You have to do this." You know, he's telling you why you should have it, but you're the one making the final decision on having it (tests) done or not...I was completely satisfied with his thoroughness, I guess, and the way he related to me. There was nothing hidden. Everything that was going on was right out there. Again, he was very, very thorough.

I. So, did he met all your expectations?

R. Yeah, that's what I expected. Exactly, exactly.

I. Has the treatment so far met with your expectations?

R. No, actually no, not really. The only treatment I've had so far is Prednisone, which, you know, medicine! And that supposedly did do the job and stop the scarring, but I've had nothing else. Like actually, I wanted to go on some rehabilitation program, and no one has ever suggested that.

I. Were the treatments explained to you in terms of what they would do and how they would help you?

R. Umm, to a certain extent. They weren't sure what, exactly, it was going to do. They did explain the side effects of it, you know, and what to do and not do, what it's supposed to do if it does indeed work. Like it was actually experimental, I guess you would say.

I. Did they tell you it was experimental?

R. Yeah, it was explained. So, no false hopes, it was their hope that it would work.

I. What are some of the things that you typically do, as a patient, during examinations and consultations?

R. Um, good question...Well by now, I pretty well know the line of questioning, you know, what they're going to be asking, so I try to prepare myself by keeping notes of

things that happened to myself and trying to remember dates, like when I was last sick.

I. Do you bring these notes with you to the examination to help you remember things?

R. No, I don't go that far. I have a pretty good memory, but I keep notes at home and stuff, so I'll kind of prepare myself.

I. When you first found out about your illness, did you start to read up on it yourself?

R. Yeah, I got a lot of information. Actually I came to [a local health and information service] and they did supply me with a lot of information on the cobalt industry. And I went to the library... Information was very hard to get. Information at the library was very sketchy.

I. How helpful was the information received from the information service?

R. Very helpful, very helpful. It really made me identify the symptoms I was having. It made me ask the proper questions. I think that if I had gone to the doctor without this information I wouldn't have known or brought my workplace into it, that's how misinformed I was. Therefore, by the time I got to London (hospital) with my work history, it really helped me pursue that angle.

I. Do you feel this information helped you be more active in the relationship with your doctor?

R. Yeah I do. I even found myself bringing literature to my doctor.

I. Did you find this helped you have a greater feeling of control over the whole situation?

R. Yeah, yeah I did, maybe that's why I wasn't intimidated. I felt like I really knew something here and I wanted them to know also, rather than just going to them just for advice type of thing. Now this Dr. J. (general practitioner) I'm going to now was one of these doctors that wasn't really aware of the workplace thing. He was very limited about occupational stuff where I think I could say he learned a good lesson from the stuff I brought him, and it really helped him in that way.

I. Do you think it was a plus for you to be able to tell him certain things?

R. Yeah it was, it really was. The thing that impressed me about him was he went beyond the call of seeing the patient from nine to five. He actually did a lot of homework on this thing. He read up about it, he found out about it, he learned about it, you know, just from my suggestions which really impressed me.

- I. Have you ever had an experience where you felt you were being talked down to by a physician, where some of your concerns were dismissed?

R. Just recently, in the last three weeks, in Toronto. I went to this respirologist where he tried to talk me into going through this series of tests to try to disprove that it (HMD) was work-related, which I was totally upset about, and he basically wanted to make things simple for everyone.

I. So, were you upset that he was trying to make things easier for himself rather than being really concerned about you?

R. Exactly, that's the big thing, there was no concern for me whatsoever. Those tests I would have gone through would have ~~actually~~ impaired me more, would have decreased my lung capacity by taking a chunk out of it. It was just his whole attitude, you know. He came and talked to us about this lung biopsy thing and I was shocked by that and said, "What are you talking to us about?" and he said, "Put an incision down here (chest)" and take a chunk about the size of a golf ball out of my lung. And he kept saying, "Oh don't worry about, you'll come around in about two or three weeks, you're a young guy." Like no concern for the chest tubes sticking out of me for two or three weeks, or being away from home. You know, there was no sympathetic attitude whatsoever, just, "That's the way it is, you're going to be in the hospital." So I was not happy with him.

I. How would you describe the ideal doctor-patient relationship?

R. Well, first of all, I think honesty is really one thing. The doctor has to be honest with the patient, and not so much honesty with just that patient, but with others involved. That's his duty, he has to do it. And he has to go beyond the call of duty. I think that in an ideal situation a doctor has to do those type of things...And if he tells you one thing he has to stick to it. He can't change it when the scene changes and it's not to his liking.

CHAPTER NINE

DISCUSSION AND CONCLUSIONS

After analyzing the responses of patients concerning their experiences with physicians one is still left with the question, how does one really know whether people are still "satisfied" or "dissatisfied" with the interaction process, with treatment recommendations, and with their doctors in general? Stimson and Webb (1975:78) maintain that satisfaction and dissatisfaction are concepts that are difficult to operationalize in research. However, this is not intended to be a study of patient satisfaction. Rather, the recorded responses of patients are intended to provide testimony of their efforts to succeed in the interaction process. Thus what patients say about their physicians in terms of "good" experiences or "bad" experiences should be seen as providing the framework for understanding the problems associated with power and social influence in the patient-physician relationship, and not as an indication of "real" experiences.

GOOD DOCTORS/BAD DOCTORS

From the array of responses recorded for this study it became apparent that most of the "bad" experiences involved interaction with traditional types of doctors. Offhandedness, rudeness, not answering questions, not having enough time - all these characteristics are part of

being a "bad" doctor. In many cases, such "bad" doctor qualities will push a patient towards a consumerist perspective. As one woman indicated:

He really didn't answer my questions at all, he just sort of told me off. So I'll make sure I never go to him again.

It was also significant that many of the reports about "bad" doctors were not presented as such, and in fact, would be prefaced with remarks such as: "She's nice, she's awfully nice, but she's very rushed...I don't have much time to ask questions." As mentioned in Chapter Seven, excuses for what patients perceive to be inappropriate behavior can be made. Therefore, many "bad" doctors are not condemned for failing to meet a patient's expectations.

It was rare among the patients interviewed for this study for a particular doctor to be judged as "bad" because of dissatisfaction with medical performance. (As indicated earlier, some patients put up with the "poor bedside manner" of an authoritarian type in order to receive the benefits of his or her specialized skills). Similarly, the criteria for judging a "good" doctor were usually not his or her clinical skills or expert knowledge. Such qualities as a willingness to listen, spending the desired time with the patient to answer all their questions, and displaying a sense of concern for the patient, topped the list of characteristics of "good"

doctors. Although doctors do report "good" experiences with physicians in spite of poor communication, responses of what they define as the ideal doctor-patient relationship suggest that the above qualities, which are characteristics of referent power, are what patients expect or desire from their physicians. The reason why qualities that are synonymous with a good bedside manner are given such high regard by patients reflects the fact that it is the doctor's social and not his or her medical skills that most patients are in a position to judge. A recurring theme, specifically among Passive and Demanding Patient types, was the "good" doctor who had time to listen to them, and in many instances, a great deal more emphasis was put on their ability to listen than their ability to advise.

THE FUNDAMENTALS OF CHANGE

It was evident from the analysis of face-to-face interaction, that for many patients, seizing control and influence is almost as difficult as persuading the physician to cede it. Patients want their doctor to be right, they want to like them and be liked themselves, and most of them want to believe that they are being treated as equals by their doctors. For people who are not Active Patient types, it is easier to rely on the authority of an "expert" than to seek advice from others or gather

information on their own. As Roberts (1985:116) points out, "To treat the doctor as an expert amongst many involves the frightening task of taking on power oneself."

Some patients reported that during face-to-face interaction they made lists to refer to, asked questions, and wrote things down so as not to forget them. However, it was found that patients only take such action under certain circumstances. Also, one can speculate that anxious glances at a long list or flippant responses from a physician can cause a patient to abandon this influencing strategy. I have pointed out that other control and influencing strategies used by patients can have a certain level of success. "Repetition" is a strategy where patients repeat statements about a particular problem in order to persuade a doctor to take some sort of desired action. Likewise, an "appeal to the normal" where patients make reference to what is claimed as the usual course of action, can influence physicians into ceding to the concerns and demands of the patient. However, such control strategies can be rendered useless, especially if a physician feels the patient is being "hysterical" or "illogical" or is generally ignorant of the medical aspects of his or her problems. Moreover, it can be very difficult to be insistent on such matters if the doctor is being reassuring and sympathetic and the patient wants to be told everything will be alright.

One of the things that makes patients so powerless when they are interacting with physicians, is the fact that the doctor is assumed to hold all the knowledge about what is wrong with the patient and what can be done. As I have mentioned, doctors are perceived to control access to themselves and to valued resources - information and treatment - which can be made available to the patient. What the physician has and what the patient wants is the physician's knowledge about illness and treatment. The difference between professional, medical knowledge and lay knowledge about illness and treatment has been viewed as a competence gap. (The competence gap epitomizes many other professional-client relationships). This view sets up the knowledge of the physician as superior in all respects and measures lay knowledge against it.

Usually the patient does lack the technical skill and knowledge that a doctor has, even the most active information seeker will bow to the physician's superior knowledge on specialized techniques. However this does not necessarily mean that the patient is granting a physician absolute power; they may still demand to be informed and involved in all aspects of their care. Opportunities for open discussion and mutual decision-making should not cease just because a patient acknowledges a physician expertise. Consider the following example concerning a woman whose five year-old daughter had undergone plastic

surgery:

On the procedure, that was totally in his hands. On the sophistication of it, I mean we're taking real specific specialized skill here...But one thing I really had a lot of input in was the interim care. I really felt that I had to become informed. Like, it was very hard to feed C., it took up to an hour and a half. It was a very inventive procedure that we (doctor and mother) made up to feed C. I did a lot of that part of it, so I had a real part.

Thus, doctors can use referent power in promoting patient participation in combination with their role as expert. For the participants in a doctor-patient relationship the degree of knowledge about medicine in general, or a particular medical problem, will vary from relationship to relationship. But an absolutist view of the discrepancy in knowledge neglects certain problems. Stimson and Webb (1975:131) point out that a doctor's knowledge of medicine is never really complete:

He [sic] can never be certain of the outcome of the actions he takes; medicine operates at the level of the probable course of an illness and probable effect of treatment. Secondly, the doctor never has a complete monopoly over the relevant medical knowledge: the patient can acquire medical knowledge from other sources. Thirdly, the doctor is never in possession of all the information that may be relevant to a particular illness - especially information held by the individual patient.

The emphasis on the competence gap in patient-physician relationships fails to take into account the fact that the patient is rarely in a state of complete ignorance. It appears that in many cases, doctors and patients are held back in their thinking by social role-sets of behavior that prescribe inferior status to

patients and superior status to physicians. As we have seen, patients assume a lot about the competency and expertise of their doctors. The physician's role as powerholder has been protected in the public's eyes; after all, society has, in part, helped to create and maintain the legitimacy of the physician's role as expert. To be sure, the title of doctor yields instant prestige and credibility.

What, then, are the basic principles of change that need to be considered? As I have suggested, in many respects, the roles of patient and doctor are predefined, and in the words of Helen Roberts (1985:118) "one is often tempted to think that there are good and bad actors in both roles". However, this does not mean that changes within the interaction game cannot take place. Insofar as change does take place, it needs to take place on both sides. Patients, specifically Passive Patient types, need to be strengthened and employ the use of information seeking as a strategy to narrow the competence gap between themselves and their physicians. Furthermore, doctors need to be educated in a way which enables them to support their patients, this includes sharing knowledge and information with the patient.

As I have mentioned, information seeking appears to be the patient's best course of action for exerting control and social influence in the doctor-patient

relationship. Johnson (1971) supports the idea of information sharing as a strategy available to patients, and argues that the nature of doctor-patient relations could change as a result of medical knowledge increasing. He suggests that despite medicine becoming increasingly specialized and thus, extending physician control, information seeking can increase a patient's ability to exert control in his or her relations with a physician (Stimson and Webb, 1975:144). Huntingford (1975) also supports the idea of information seeking by patients and promotes the use of referent power by doctors in allowing patients to participate more fully in face-to-face interaction. In an interview reported in The Listener, Huntingford talks about the worst sort of patient-physician relationship:

The worst is no doubt where the doctor really believes that he [sic] knows what is right for those that seek his help. The next worst is where those seeking help believe that the doctor knows best...I think people ought to challenge the profession and say: "I want you to treat me as I treat you, namely with respect," but not with such respect that they cannot say, "I don't believe what you're saying and I don't like the way you're doing it. Are there any choices? Why can't I be involved in the choice? Women and men should be able to do this with their doctor (1975:118).

However, as the findings in this study indicate, many doctors, especially traditional types, resist sharing knowledge and information with their patients, as this serves to "demystify" their role as expert. As Goffman (1959:70) points out:

The audience senses secret mysteries behind the performance, and the performer senses that his chief secrets are petty ones. As countless folk tales and initiation rites show, often the real mystery is that there really is no mystery; the real problem is to prevent the audience from learning this too.

Social researchers such as Haas and Shaffir (1977), Rodin and Janis (1972), Roberts (1985), and Webb (1986), maintain that educating doctors to better support their patients should involve, among other things, a better understanding of what it is to be ill, and what it is to be healthy, as well as a proper understanding that patient is qualified in ways that the doctor is not. It is the patient and not the doctor - however skilled - who knows what it is like to have a particular illness in the context of their reality. Thus, both doctor and patient can learn from each other.

In the examination of patient types, we have seen that patients differ in regard to how active and creative they are during encounters with a physician. Nevertheless, patients being people, report that they like to be actively involved at some level in what is happening to them. Thus change in the power structure of doctor-patient relationships need to take into consideration the validity of the patient's viewpoint. For doctors, this involves seeing the patient as a participant, rather than objectifying patients as recipients of medical care.

CHAPTER TEN

RECOMMENDATIONS

It is quite evident that the use of referent power in the physician-patient relationship requires particular skills which can and should be taught to physicians and medical students as part of educating them to support and promote patient participation. To be sure, some physicians may not be able to develop such a relationship - and indeed, many physicians will not be able to develop a referent relationship with all of their patients. One problem with referent power is that it can be inconsistent with expert or legitimate power, which are based upon a perception of difference and superiority rather than mutuality and similarity (Johnson, et. al, 1982:16). If expert and legitimate power are also to be utilized it takes particular skills to avoid conflict between power bases. As we have seen, for some patients, it is difficult to ascribe superior knowledge to physicians and at the same time see them as basically like oneself. Also, it is reasonable to assume the choice of the most effective basis of power, be it expert, referent, or some amalgam of both, must be a function of the nature of the practitioner, the patient, the type of behavior being influenced, and the situational and cultural variables present in the relationship. For example, a physician's expert power can easily be negated by the patient or by a

member of the patient's family who refuses a particular treatment for ethnic or religious reasons or on the advice of professional or non-professional others. Also, the severe nature of the patient's condition can make effective communication with that patient impossible.

I have shown that in patient-physician relationships there is quite a variance in the circumstances that promote a challenging of opinion and mutual decision-making and what it means to the patient in terms of having a sense of control over his or her own health. Some patients report that they prefer to be actively involved in all aspects of their health care no matter how minor the problem. Others take on traits of the active consumer only when they perceive the situation to be serious enough to warrant such action. Still, some patients prefer to defer the responsibility of their health care on the shoulders of the doctor, no matter what the circumstances.

The analysis and discussion of the three stages of interaction indicate the traditional model and the new patient as equal model can work for certain people under certain circumstances, insofar as patients report that they are satisfied with the care that they received. This can lead one to suggest that it may be appropriate for social scientists and health-care experts to promote a consumerist perspective where patients feel they can shop

around for the "type" of doctor that best matches their expectations.

However this researcher has found that many patients, even Active Patients types, are not always inclined to take consumerist actions when they feel that their doctors do not have their best interests in mind. When questioned why they did not challenge or change doctors after reporting a "bad experience" with a particular physician, some interviewees implied that it was "too much trouble" or "it's not my style." One woman responded, "Switch doctors? Well you can't just switch doctors. You have to be referred, I know that."

Thus, patients do not always perceive consumerism to be a viable option to pursue when they experience problems within a particular relationship with a doctor. Furthermore, the recorded array of responses to the question, "How would you describe the ideal doctor-patient relationship?", indicated that almost all the patients interviewed idealize the traits that are characteristic of a patient as equal approach to health care. It is for these reasons that I agree with those researchers that promote referent power and endorse an antielitist perspective in regard to power and social influence in the patient-physician relationship.

It is likely that contact with a physician who is using referent power can reduce anxiety in patient. By

giving reassurance and empathy, and satisfying the patient's stress-induced desire for interpersonal contact, a doctor can alleviate fear and related emotional states. Even if a business-like physician is using expert power to the limit, his or her effectiveness would be expected to increase by adopting one or another of the means for also acquiring social power as a significant reference person in the life of the patient. By adding referent power to other bases of social power, such as expert, legitimate, reward, or informational power, a physician would become an even more highly esteemed helper with whom the patients are more likely to identify. Then his or her health-promoting recommendations would not only meet with less initial psychological resistance, but would also be more consciously adhered to long after the consultations have come to an end.

We have seen quite clearly that some physicians cannot spend enough time with their patients to become referent individuals. As indicated in the responses of many individuals, physicians are perceived to be too busy to do this. The use of teamwork in health care may be the answer here. Nurses and paramedics, acting as members of a team, and thus representatives of the staff, can be used to make sure that the health regimens are clearly understood and followed. Their effectiveness may be greatly enhanced by developing referent power. As one male

patient stated:

Part of the doctor's service is the nursing staff. That was one of the reasons why I left my old doctor, I had a perfectly good doctor before, but his nurse was rather uncourteous...Like I said a good nursing staff should be part of the overall service.

One woman, who left the hospital with a dressing over some stitches, reported:

I should have been told how to change that which I wasn't. I was a little concerned about that, never having done that before...I felt that if it was explained to me by the nurses or somebody, I would have felt a little more reassured.

Teamwork can both facilitate and increase the effectiveness of referent power in health care today. Barbara Bates (1970:132) described a controlled study in which a group of patients were cared for in nurse clinics, successfully amalgamating an expanded nurse role with physician participation. When compared with the patients receiving traditional medical-clinic care, their nurse-clinic patients showed less disability, fewer symptoms, fewer broken appointments, fewer criticisms of their care, and decreased use of other medical resources. Another controlled study, reported by Bates (1970:132) in regard to the use of teamwork and referent power, has shown similar results. When a nurse's interview supplemented a physician's examination in an initial student-health evaluation, the students reported a greater opportunity to discuss their problems, a clearer idea of services available, and a greater sense of the staff's interest in

them as individuals.

Feminist health care reports similar success in regards to the use of teamwork. Doctors Maggie Eisner and Maureen Wright worked together for four years in a general practice in London, England, in an attempt to set up an alternative to conventionally organized practice. Eisner and Wright (1986:125) describe their experience after the experiment ended in 1984:

The democratic atmosphere allowed us to develop an open, informal approach to staff and patients...We also felt free to be honest with the patients and other workers about the stresses affecting our behavior on a particular day, such as feeling unwell, having a sick child at home, or running late, rather than having to try to appear infallible.

Thus, the effective use of teamwork and referent power can be profoundly beneficial for not only the patient but for the physician as well, insofar as alleviating stress by dismissing the notion that physicians must display an air of superiority and infallibility.

Eisner and Wright (1986:125) continue:

We also learned how to help patients gain more control in outside situations, by involving them in decisions about their own health care, and by providing as much information as possible. Even when medical information is made available to people, it may be in incomprehensible jargon, and we learned to fulfill a valuable role as interpreters of such medical mystification.

On the basis of what has been presented, it seems likely that the effective use of referent power as a part of a new model in the physician-patient relationship could have profoundly beneficial results, and it is for this reason that good interdisciplinary research is so greatly needed, especially among medicine, social science, and allied health professions. It is apparent that the necessity for physicians to use referent power may require an expansion of their knowledge and skills or the development of new types of specialists working alongside the physician. Thus, changes at a systems level as well as the individual level, may be required.

It also seems likely that by using referent power in a patient as equal approach, the health care task will probably be accomplished more effectively as the patient is involved as fully as possible at every stage of the treatment, which might be better viewed as an "interpersonal, problem solving transaction" (Johnson, et. al; 1982:74). Since every interaction is a mutual influence process, the patient is actively utilizing some degree of social power since he or she is directly involved in decision making. It is important that patients and doctors share power and social influence in their relationships together, for it is in this manner that they come to support each other in the task of caring and healing.

APPENDIX

INTERVIEW GUIDE

Describe your experience[s] (or that of a close family member) with a physician[s] in the past five years beginning with the most recent.

- Probe for
- basic demographics of the patient (age, sex, social class, occupation, etc.), and of the doctor (sex, approximate age, area of practice or specialty).
 - nature of the illness and length of contact with the physician
 - social background of the patient and doctor
 - feelings of "reactance"
 - perception of information sharing
 - perception of mutual decision-making
 - challenging of opinion
 - how any conflict was resolved
 - patients expectations of the relationship

Describe your perception of the patient role.

- Probe for
- what degree they perceive themselves as being active and self-determining
 - how important to the patient is a sense of control over health relevant outcomes
 - types of power used by the patient
 - challenging of opinions and mutual decision-making (how important is this to the patient and under what circumstances)

Describe your perception of your doctor's role.

- Probe for
- types of power used by the physician
 - the extent that each type of power was used by the physician
 - information sharing and mutual decision-making
 - under what circumstances was the use of one type of power perceived by the patient to be better than the use of another type

Describe what you perceive to be the ideal doctor-patient relationship.

- Probe for
- sharing of power (the relationship as a meeting between equals)
 - information sharing
 - concerns for mutual decision-making
 - feminist concerns

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